2021

CUMULATIVE SUPPLEMENT

TO

MISSISSIPPI CODE

1972 ANNOTATED

Issued September 2021

CONTAINING PERMANENT PUBLIC STATUTES OF MISSISSIPPI
ENACTED THROUGH THE 2021 REGULAR SESSION

PUBLISHED BY AUTHORITY OF
THE LEGISLATURE

SUPPLEMENTING

Volume 19A

Title 83 (Chapters 21 to 85)

(As Revised 2011)

For latest statutes or assistance call 1-800-833-9844

By the Editorial Staff of the Publisher

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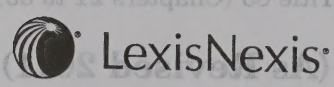

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9443 Springboro Pike, Miamisburg, OH 45342

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User's Guide

In order to assist both the legal profession and the layman in obtaining the maximum benefit from the Mississippi Code of 1972 Annotated, a User's Guide has been included in the main volume. This guide contains comments and information on the many features found within the Code intended to increase the usefulness of the Code to the user.

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PUBLISHER'S FOREWORD

Statutes

The 2021 Supplement to the Mississippi Code of 1972 Annotated reflects the statute law of Mississippi as amended by the Mississippi Legislature through the end of the 2021 Regular Legislative Session.

Annotations

Case annotations are included based on decisions of the State and federal courts in cases arising in Mississippi. Annotations to collateral research references are also included.

To better serve our customers by making our annotations more current, LexisNexis has changed the sources that are read to create annotations for this publication. Rather than waiting for cases to appear in printed reporters, we now read court decisions as they are released by the courts. A consequence of this more current reading of cases, as they are posted online on LexisNexis, is that the most recent cases annotated may not yet have print reporter citations. These will be provided, as they become available, through later publications.

This publication contains annotations taken from decisions of the Mississippi Supreme Court and the Court of Appeals and decisions of the appropriate federal courts. These cases will be printed in the following reporters:

Southern Reporter, 3rd Series
United States Supreme Court Reports
Supreme Court Reporter
United States Supreme Court Reports, Lawyers' Edition, 2nd Series
Federal Reporter, 4th Series
Federal Supplement, 3rd Series
Federal Rules Decisions
Bankruptcy Reporter

Additionally, annotations have been taken from the following sources:

American Law Reports, 6th Series
American Law Reports, Federal 2nd
Mississippi College Law Review
Mississippi Law Journal

Finally, published opinions of the Attorney General and opinions of the Ethics Commission have been examined for annotations.

Amendment Notes

Amendment notes detail how the new legislation affects existing sections.

Editor's Notes

Editor's notes summarize subject matter and legislative history of repealed sections, provide information as to portions of legislative acts that have not been codified, or explain other pertinent information.

Joint Legislative Committee Notes

Joint Legislative Committee notes explain codification decisions and corrections of Code errors made by the Mississippi Joint Legislative Committee on Compilation, Revision, and Publication of Legislation.

Tables

The Statutory Tables volume adds tables showing disposition of legislative acts through the 2021 Regular Session.

Index

The comprehensive Index to the Mississippi Code of 1972 Annotated is replaced annually, and we welcome customer suggestions. The foreword to the Index explains our indexing principles, suggests guidelines for successful index research, and provides methods for contacting indexers.

Acknowledgements

The publisher wishes to acknowledge the cooperation and assistance rendered by the Mississippi Joint Legislative Committee on Compilation, Revision, and Publication of Legislation, as well as the offices of the Attorney General and Secretary of State, in the preparation of this supplement.

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September 2021 LexisNexis

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Added in this Supplement

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§ 83-21-1. Certificate of authority; funding of agency expenses; deposit of monies into State General Fund.

No foreign insurance, indemnity or guaranty company or other insurer shall be admitted and authorized to do business in this state until:

(a) It shall deposit with the Commissioner of Insurance a certified copy of its charter, articles of incorporation, bylaws or deed of settlement, and shall pay for the filing of such document the sum of One Thousand Dollars ($1,000.00) and a statement of its financial condition and business in such form and detail as he may require, signed and sworn to by its president and secretary or other proper officer.

(b) It shall satisfy the commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact; and such capital or net assets are well invested and immediately available for the payment of losses in this state, and that it insures on any single hazard a sum no larger than one-tenth (1/10) of its net assets.

(c) It shall, by a duly executed instrument filed in his office, constitute and appoint the Commissioner of Insurance, and his successor, its true and lawful attorney, upon whom all process in any action or legal proceeding against it may be served, and therein shall agree that any process against it which may be served upon its attorney shall be of the same force and validity as if served on the company, and the authority thereof shall continue in force irrevocable so long as any liability of the company remains outstanding in this state. The service of such process shall be made by leaving a copy of the same in the hands or office of the commissioner. Copies of such instrument certified by the commissioner shall be deemed sufficient evidence thereof, and service upon such attorney shall be deemed sufficient service upon the principal.

(d) It shall appoint as its agent or agents in this state some resident or residents thereof, other than the commissioner; such appointment to be made in writing, signed by the president and secretary or manager or general agent, and filed in the office of the commissioner, authorizing the agent to acknowledge service of process for and on behalf of the company, consenting that service of process on the agent shall be as valid as if served

upon the company, according to the laws of this state, and waiving all claims of error by reason of such service.

(e) It shall obtain from the commissioner a certificate that it has complied with the laws of the state and is authorized to make contracts of insurance.

(f) Such fees collected by the commissioner shall be deposited in the special fund in the State Treasury designated as the "Insurance Department Fund."

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1906, § 2606; Hemingway's 1917, § 5069; 1930, § 5165; 1942, § 5672; Laws, 1977, ch. 326; Laws, 1977, ch. 395; Laws, 1982, ch. 391, § 1; Laws, 1988, ch. 526, § 7; Laws, 1991, ch. 429 § 1; Laws, 2003, ch. 347, § 1; Laws, 2016, ch. 459, § 32, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides: "SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Amendment Notes — The 2016 amendment added the last two paragraphs.

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

§ 83-21-3. Requirements for admission.

(1)(a) No foreign insurance company, association, or other insurance entity, either stock, mutual, or reciprocal, shall be admitted to do business or granted a certificate of authority or license to do business in this state unless and until such company or association shall have done business for a period of at least two (2) years in the state of its domicile, or unless such company seeking admission is the subsidiary or affiliate of a company already licensed in Mississippi.

(b) The Commissioner of Insurance may waive this requirement upon a written request by the applicant and a finding that the applicant meets the following criteria:

(i) The company provides a service that is considered underserved in the state;

(ii) The company has adequate capital and surplus; and

(iii) The company possesses significant management and business experience in its respective line of business.

(2) No foreign stock insurance company shall be admitted or granted a certificate of authority or license to do business in this state unless its paid-up

capital stock and its surplus at the time of licensing or renewal of license shall be equal to that required for the organization or incorporation of a like domestic company under the laws of this state.

(3) No foreign mutual or reciprocal insurance company or association shall be admitted or granted a certificate of authority or license to do business in this state unless, at the time of licensing or renewal of license, its surplus shall be equal to that required by the laws of this state for the organization or formation of a like domestic insurance company or association.

(4) No foreign stock, mutual, or reciprocal insurance company or association, incorporated or organized under the laws of any state of the United States, shall be admitted to do business, or granted a certificate of authority, or have license therefor renewed until such company shall have deposited with the State Treasurer of this state securities in an amount not less than Fifty Thousand Dollars ($50,000.00). Securities deposited in accordance with this section shall be classified as admitted assets for the purpose of determining eligibility of such securities. Provided, however, any company maintaining a deposit with the insurance regulatory authority or any other designated public official of its state of domicile, or of any other state, in trust for the benefit of all its policyholders, or policyholders and creditors, may be exempt from the deposit herein provided upon such company delivering to the Commissioner of Insurance a certificate to such effect, duly authenticated by the appropriate state official holding such deposit. The commissioner may require in addition to the certification of deposit by the public official of its state of domicile an amount not less than Fifty Thousand Dollars ($50,000.00) be deposited with the State Treasurer of this state. Any deposit made in this state under the provisions of this section shall be for the exclusive use and benefit of policyholders, or policyholders and creditors, in this state; and such deposit shall not bar claim to other assets of the company by policyholders, or policyholders and creditors, in this state in the event of insolvency, receivership, or liquidation of the company.

Notwithstanding any other provision of law, the securities eligible for deposit under the insurance laws of this state relating to deposit of securities by an insurance company as a condition of commencing or continuing to do an insurance business in this state may be deposited with a clearing corporation or held in the Federal Reserve book-entry system. Securities deposited with a clearing corporation or held in the Federal Reserve book-entry system and used to meet the deposit requirements under the insurance laws of this state shall be under the control of the Commissioner of Insurance and shall not be withdrawn by the insurance company without the approval of Commissioner of Insurance. Any insurance company holding securities in such manner shall provide to the Commissioner of Insurance evidence issued by its custodian or member bank through which such insurance company has deposited such securities in a clearing corporation or through which such securities are held in the Federal Reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or other direct participant or member bank, and that the records of

the custodian, other participant or member bank reflect that such securities are held subject to the order of the Commissioner of Insurance.

(5) In case any insurer which has made a deposit with the Commissioner of Insurance, or other designated official or custodian in this state, of cash or securities in trust for the protection of its policyholders or creditors or both in this state, or of its policyholders or creditors or both in the United States, thereafter becomes merged or consolidated in accordance with the laws of this state if a domestic insurer, or in accordance with the laws of its domiciliary state or nation if a foreign or alien insurer, and upon the effectuation of the merger or consolidation, the resulting corporation is or becomes authorized to do business in this state, the commissioner, or other designated official or custodian, as the case may be, upon the resulting corporation's being so authorized, shall release and transfer the cash or securities so deposited by the merged or consolidated insurer to the resulting corporation, or to such person as it may designate to take and receive the same.

If any insurer which has made such a deposit with the Commissioner of Insurance or other designated official or custodian in the state hereafter withdraws from and ceases to do business in this state, and has paid or provided for the payment of all its obligations and liabilities to its policyholders and creditors in this state by the assumption or reinsurance of the same by an insurer which is or becomes authorized to transact business in this state, the Commissioner of Insurance or other designated official or custodian, as the case may be, shall release and transfer the cash or securities constituting its deposit to such withdrawing insurer, or to such person as it may designate to take and receive the same.

Any release or transfer pursuant hereto shall be made upon application to and the written order of the Commissioner of Insurance. Neither the Commissioner of Insurance, nor other designated official or custodian, as the case may be, shall have any liability for the release or transfer of any such deposit made or authorized in good faith.

HISTORY: Codes, 1942, § 5677.5; Laws, 1956, ch. 333, §§ 1-3; Laws, 1958, ch. 442, § 1; Laws, 1962, ch. 462, § 1; Laws, 1991, ch. 420 § 1; Laws, 2001, ch. 412, § 6; Laws, 2013, ch. 459, § 19, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment added (1)(b); and substituted "Commissioner of Insurance" for "Insurance Commissioner" throughout the section.

§ 83-21-19. Resident and nonresident surplus lines insurance producers; licensing; fees; suspension, revocation or refusal of license; grounds; notice; hearing.

(1) Surplus lines insurance may be placed by a surplus lines insurance producer if:

(a) Each insurer is an eligible surplus lines insurer;

(b) Each insurer is authorized to write the line of insurance in its domiciliary jurisdiction; and

(c) All other requirements as set forth by law are met.

(2) The Commissioner of Insurance, upon the biennial payment of a fee of One Hundred Dollars ($100.00) and submission of a completed license application on a form approved by the commissioner, may issue a surplus lines insurance producer license to a qualified holder of an insurance producer license with a property, casualty and/or personal lines line of authority, who is regularly commissioned to represent a fire and casualty insurance company licensed to do business in the state.

(3) The privilege license shall continue from the date of issuance until the last day of the month of the licensee's birthday in the second year following issuance or renewal of the license, with a minimum term of twelve (12) months.

(4) A nonresident person shall receive a surplus lines insurance producer license if:

(a) The person is currently licensed as a surplus lines insurance producer or equivalent and in good standing in his or her home state;

(b) The person has submitted the proper request for licensure and has paid the biennial fee of One Hundred Dollars ($100.00); and

(c) The person's home state awards nonresident surplus lines licenses to residents of this state on the same basis.

(5) The commissioner may verify a person's licensing status through the National Producer Database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

(6) A nonresident surplus lines insurance producer licensee who moves from one (1) state to another state, or a resident surplus lines licensee who moves from this state to another state, shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.

(7) The commissioner may deny, suspend, revoke or refuse the license of a surplus lines insurance producer licensee and/or levy a civil penalty in an amount not to exceed Two Thousand Five Hundred Dollars ($2,500.00) per violation, after notice and hearing as provided hereunder, for one or more of the following grounds:

(a) Providing incorrect, misleading, incomplete or materially untrue information in the license application;

(b) Violating any insurance laws, or violating any regulation, subpoena or order of the commissioner or of another state's commissioner;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating or converting any monies or properties received in the course of doing the business of insurance;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(f) Having been convicted of a felony;

(g) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(h) Using fraudulent, coercive or dishonest practices or demonstrating

incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

(i) Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(j) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(k) Improperly using notes or any other reference material to complete an examination for an insurance license;

(*l*) Knowingly accepting insurance business from an individual who is not licensed;

(m) Failing to comply with an administrative or court order imposing a child support obligation; or

(n) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(8) If the action by the commissioner is to nonrenew, suspend, revoke or to deny an application for a license, the commissioner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the commissioner within ten (10) days for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held within thirty (30) days.

(9) Every surplus lines insurance contract procured and delivered according to Sections 83-21-17 through 83-21-31 shall have stamped upon it in bold ten-point type, and bear the name of the surplus lines insurance producer who procured it, the following: "NOTE: This insurance policy is issued pursuant to Mississippi law covering surplus lines insurance. The company issuing the policy is not licensed by the State of Mississippi, but is authorized to do business in Mississippi as a nonadmitted company. The policy is not protected by the Mississippi Insurance Guaranty Association in the event of the insurer's insolvency." No diminution of the license fee herein provided shall occur as to any license effective after January 1 of any year.

HISTORY: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1977, ch. 397; Laws, 1988, ch. 526, § 9; Laws, 2000, ch. 606, § 1; Laws, 2009, ch. 448, § 13; Laws, 2011, ch. 380, § 3; Laws, 2017, ch. 339, § 1, eff from and after July 1, 2017.

Amendment Notes — The 2017 amendment deleted former (1)(c), which read: "The full amount or type of insurance cannot be obtained from insurers who are admitted to do business in this state. The full amount or type of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular type of insurance in this state, if any are writing it; and" and redesignated former (1)(d) as (1)(c); substituted "represent a fire and casualty insurance company" for "represent two (2) or more fire and casualty companies" in (2); and deleted former (5), which read: "A nonresident person shall not be required to hold an insurance producer license with a property, casualty and/or personal lines line of authority if the person is not required to perform a diligent search of admitted insurers as set forth in Section 83-21-23," and redesignated the remaining subsections accordingly.

§ 83-21-21. Surplus lines policies.

Editor's Notes — Laws of 2015, ch. 471, § 5, provides:

"SECTION 5. The State Fiscal Officer shall transfer the sum of Three Million Dollars ($3,000,000.00) from the Mississippi Surplus Lines Association to the Mississippi Department of Insurance Rural Fire Truck Acquisition Fund and/or the Supplemental Rural Fire Truck Fund. The Mississippi Department of Insurance shall notify the State Fiscal Officer which of those two (2) fund(s) that the Three Million Dollars ($3,000,000.00) shall be transferred to."

§ 83-21-23. Surplus lines insurance producer required to execute and retain form setting forth certain facts; promulgation of rules and regulations and establishment of fees; exemption of certain surplus lines insurance producers from requirement to make due diligence search to determine availability of full amount or type of insurance from admitted insurers under certain circumstances.

(1) When any policy of personal lines insurance is procured under the authority of such license, the surplus lines insurance producer shall furnish to the insured at the time of policy deliverance an informational notice as promulgated by the commissioner. The informational notice shall address the following:

(a) The insurance procured may or may not be available from the admitted market that may provide greater protection with more regulatory oversight;

(b) In the event of an insolvency of the surplus lines insurer, losses shall not be paid by the Mississippi Insurance Guaranty Association;

(c) The coverage has been procured through a duly licensed nonadmitted insurance producer; and

(d) Any other information the commissioner believes should be disclosed to the insured.

(2) The Commissioner of Insurance may promulgate rules and regulations and establish appropriate fees for the implementation of Sections 83-21-17 through 83-21-31.

HISTORY: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; § 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1993, ch. 308, § 1; Laws, 1995, ch. 314, § 1; Laws, 2000, ch. 606, § 2; Laws, 2011, ch. 380, § 5; Laws, 2012, ch. 309, § 1; Laws, 2017, ch. 339, § 2, eff from and after July 1, 2017.

Amendment Notes — The 2012 amendment in (1), inserted "a form" following "lines insurance producer" in the first sentence, deleted "and further showing that the amount of insurance procured from the eligible nonadmitted insurer or insurers is only the excess over the amount so procurable from licensed companies. Each such affidavit, which shall be effective for the term of the policy, shall be filed with the Commissioner of Insurance along with the report required in Section 83-21-25" and added the last

sentence.

The 2017 amendment rewrote the first paragraph of (1), which read: "When any policy of insurance or certificate of insurance is procured under the authority of such license, there shall be executed by the surplus lines insurance producer a form setting forth facts in complete detail as to what was done to place such kind of insurance and showing that such surplus lines insurance producer therein was unable, after diligent effort, to procure from a licensed company or companies the full amount of insurance required to protect the property, liability, or risk desired to be insured. This form shall be maintained on file with the surplus lines insurance producer and may be subject to review by the Commissioner of Insurance at any time if the commissioner deems such request advisable"; added (1)(a) through (d); designated the former last paragraph of (1) as (2); deleted former (2)(a), which provided that a surplus lines insurance producer was not required to make a due diligence search to determine whether the full amount or type of insurance could be obtained from admitted insurers when the surplus lines insurance producer was seeking to procure or place nonadmitted insurance for an exempt commercial purchaser; and deleted former (2)(b), which defined the term "exempt commercial purchaser."

§ 83-21-25. Report of surplus lines insurance producer; "gross premiums"; designation of procuring surplus lines insurance producer to make report and payment; exemption from payment of surplus line premium tax on certain property risk.

(1) The surplus lines insurance producer shall report under oath to the Commissioner of Insurance, within thirty (30) days from the first of January and July of each year, the amount of gross premiums received by him for such insurance in nonadmitted insurers, and shall pay to the Commissioner of Insurance a tax of four percent (4%) thereon. The term "gross premiums" shall mean the total gross amount of premiums received on each and every surplus lines insurance contract, less returned premiums. In default of the payment of any sum which may be due the state under this law, the Commissioner of Insurance may sue for the same. The surplus lines insurance producer shall keep a separate record of all transactions, as herein provided, open at all times to the inspection of the Commissioner of Insurance. The surplus lines insurance producer may designate another surplus lines insurance producer that actually procured the insurance from the nonadmitted insurer to report and pay, on behalf of the surplus lines insurance producer, to the Commissioner of Insurance the tax due the state under this law. The surplus lines insurance producer designated to pay the tax shall be deemed to have the same obligations and responsibilities for reporting and paying the tax due the state on the insurance procured from the nonadmitted insurer as the surplus lines insurance producer who was initially responsible for reporting and paying the tax, and the Commissioner of Insurance may sue such surplus lines insurance producer designated to pay the tax in the event such surplus lines insurance producer is in default of any sum which is due the state for which the designated surplus lines insurance producer is responsible or obligated to pay.

(2) [Repealed].

HISTORY: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942,

§ 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1993, ch. 308, § 2; Laws, 2011, ch. 380, § 6; Laws, 2012, ch. 350, § 1, eff from and after passage (approved Apr. 16, 2012).

Editor's Notes — Subsection (2), which read: "Notwithstanding any provision herein to the contrary, the four percent (4%) tax required in subsection (1) of this section shall not apply to any property risk written by and through the Department of Finance and Administration on behalf of the State of Mississippi. This subsection shall stand repealed from and after July 1, 2013," was repealed by its own terms effective July 1, 2013.

Amendment Notes — The 2012 amendment added (2).

UNAUTHORIZED INSURERS PROCESS LAW

§ 83-21-37. Acts constituting commissioner as agent.

JUDICIAL DECISIONS

2. Applicability.

Miss Code Ann. § 83-21-37 (Rev. 2011) did not apply to an insured's claim against an insurance producer where the producer was a domestic corporation. Cent. Insurers of Gren., Inc. v. Greenwood, 268 So. 3d 493, 2018 Miss. LEXIS 237 (Miss. 2018).

CHAPTER 23.

INSOLVENT INSURANCE COMPANIES; INSURANCE GUARANTY ASSOCIATION

Article 3.	Insurance Guaranty Association.	83-23-101
Article 5.	Mississippi Life and Health Insurance Guaranty Association Act.	83-23-201

ARTICLE 3.

INSURANCE GUARANTY ASSOCIATION.

Sec.
83-23-109. Definitions.
83-23-115. Powers and duties of association.

§ 83-23-109. Definitions.

As used in this article:

(a) "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(b) "Association" means the Mississippi Insurance Guaranty Association created under Section 83-23-111.

(c) "Claimant" means any insured making a first-party claim or any

person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

(d) "Commissioner" means the Commissioner of Insurance.

(e) "Control" means the possession, direct or indirect, of the power to direct or cause direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

(f) "Covered claim" means an unpaid claim, including one of unearned premiums, which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this article applies issued by an insurer, if such insurer becomes an insolvent insurer and (i) the claimant or insured is a resident of this state at the time of the insured event, provided that for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event; or (ii) the property from which the claim arises is permanently located in this state. "Covered claim" shall not include any amount awarded as punitive or exemplary damages; or sought as a return of premium under any retrospective rating plan; or due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise and shall preclude recovery thereof from the insured of any insolvent carrier to the extent of the policy limits. "Covered claim" shall not include any claim that would otherwise be a covered claim under this article that has been rejected or denied by any other state guaranty fund based upon that state's statutory exclusions regarding the insured's net worth.

(g) "Insolvent insurer" means an insurer licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred and against whom an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction, in the insurer's state of domicile or of this state and the order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

(h) "Member insurer" means any person who (i) writes any kind of insurance to which this article applies under Section 83-23-105, including the exchange of reciprocal or interinsurance contracts, and (ii) is licensed to transact insurance in this state.

(i) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this article applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(j) "Person" means any individual, corporation, partnership, association or voluntary organization.

HISTORY: Codes, 1942, § 5814-55; Laws, 1970, ch. 446, § 5; Laws, 1992, ch. 412, § 2, eff from and after July 1, 1992; Laws, 2019, ch. 304, § 1, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment, in (f), redesignated (f)(1) and (2) as (f)(i) and (ii), and added the last sentence; and in (h), redesignated (h)(1) and (2) as (h)(i) and (ii).

§ 83-23-115. Powers and duties of association.

(1) The association shall:

(a) Be obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within thirty (30) days after the determination of insolvency, or before the policy expiration date if less than thirty (30) days after the determination, or before the insured replaces the policy or causes its cancellation if he does so within thirty (30) days of the determination. Such obligation shall be satisfied by paying the claimant an amount as follows:

(i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;

(ii) An amount in excess of Fifty Dollars ($50.00) per policy for a covered claim for the return of unearned premium;

(iii) An amount in excess of Fifty Dollars ($50.00) but not exceeding Three Hundred Thousand Dollars ($300,000.00) per claimant for all other covered claims.

In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises. Notwithstanding any other provisions of this article, a covered claim shall not include a claim filed with the association after final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

(b) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent.

(c) Assess insurers amounts necessary to pay the obligations of the association under paragraph (a) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and the cost of examinations under Section 83-23-125 and other expenses authorized by this article. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bears to the net direct written premiums of all member insurers for the preceding calendar year. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any year an amount greater than one percent (1%) of that member insurer's net direct written premiums

for the preceding calendar year. If the maximum assessment, together with the other assets of the association, does not provide in any one (1) year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer may set off, against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer.

(d) Investigate claims brought against the association; adjust, compromise, settle, and pay covered claims to the extent of the association's obligation; deny all other claims; and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties, to determine the extent to which such settlements, releases, and judgments may be properly contested.

(e) Notify such persons as the commissioner directs under Section 83-23-119(2)(a).

(f) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer.

(g) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association, and shall pay the other expenses of the association authorized by this article.

(2) The association may:

(a) Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

(b) Borrow funds necessary to effect the purposes of this article in accord with the plan of operation.

(c) Sue or be sued.

(d) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this article.

(e) Perform such other acts as are necessary or proper to effectuate the purpose of this article.

(f) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities if, at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

HISTORY: Codes, 1942, § 5814-58; Laws, 1970, ch. 446, § 8; Laws, 1992, ch. 412,

§ 4, eff from and after July 1, 1992; Laws, 2019, ch. 304, § 2, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment added the last sentence of the last paragraph of (1)(a).

§ 83-23-123. Nonduplication of recovery.

JUDICIAL DECISIONS

2. Exhaustion requirement.

Under the exhaustion of other insurance provision of Miss. Code Ann. § 83-23-123(1) (1999), the Mississippi Insurance Guaranty Association had to offset or reduce its obligation to pay a covered claim from an insolvent workers' compensation insurer where the injured employee recovered on the same claim in a settlement with an uninsured motorist carrier, which was the full obligation of that insurer. Miss. Ins. Guar. Ass'n v. Blakeney, 54 So. 3d 203, 2011 Miss. LEXIS 28 (Miss. 2011).

ARTICLE 5.

MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT.

Sec.

83-23-203. Purpose.
83-23-205. Applicability of article.
83-23-209. Definitions.
83-23-211. Mississippi Life and Health Insurance Guaranty Association; member insurers; functions; accounts.
83-23-215. Powers of association.
83-23-217. Assessments against member insurers; classes; refunds; treatment of assessments on financial statements of member insurers; protest of assessment.
83-23-219. Plan of operation; approval by commissioner; contents of plan.
83-23-221. Duties of commissioner; enforcement of assessments against member insurers; appeal.
83-23-223. Detection and prevention of member insurer insolvencies or impairments.
83-23-225. Liability of insolvent or impaired insurer for assessments.
83-23-227. Regulation by commissioner; annual report.
83-23-233. Stay of judicial proceedings upon order of liquidation, rehabilitation, or conservation.
83-23-235. Use of association's name in insurance advertisements or solicitations; association to prepare document describing general purposes and limitations of association.
83-23-237. Applicability of amendments by Chapter 358, Laws of 2014.
83-23-239. Amendments by Chapter 304, Laws of 2020, to this article not applicable to member insurers placed under liquidation order.

§ 83-23-203. Purpose.

(1) The purpose of this article is to protect, subject to certain limitations, the persons specified in Section 83-23-205(1) against failure in the perfor-

mance of contractual obligations, under life, health, and annuity policies, plans or contracts specified in Section 83-23-205(2), because of the impairment or insolvency of the member insurer that issued the policies, plans or contracts.

(2) To provide this protection, an association of member insurers is created to pay benefits and to continue coverages as limited herein, and members of the association are subject to assessment to provide funds to carry out the purpose of this article.

HISTORY: Laws, 1985, ch. 482, § 2; Laws, 1990, ch. 546, § 1, eff from and after July 1, 1990; Laws, 2020, ch. 304, § 1, eff from and after July 1, 2020.

Amendment Notes — The 2020 amendment, in (1), substituted "under life, health, and annuity policies, plans or contracts" for "under life and health insurance policies and annuity contracts," and inserted "plans" near the end; and inserted "member" near the beginning of (2).

§ 83-23-205. Applicability of article.

(1) This article shall provide coverage for the policies and contracts specified in subsection (2)(a) of this section:

(a) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under paragraph (b);

(b) To persons who are owners of or certificate holders or enrollees under the policies or contracts (other than unallocated annuity contracts and structured settlement annuities) and in each case who:

(i) Are residents; or

(ii) Are not residents, but only under all of the following conditions:

1. The member insurer that issued the policies or contracts is domiciled in this state;

2. The states in which the persons reside have associations similar to the association created by this article;

3. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(c) For unallocated annuity contracts specified in subsection (2)(a) of this section, paragraphs (a) and (b) of this subsection shall not apply, and this article shall (except as provided in paragraphs (e) and (f) of this subsection) provide coverage to:

(i) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(ii) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(d) For structured settlement annuities specified in subsection (2)(a) of this section, paragraphs (a) and (b) of this subsection shall not apply, and

this article shall (except as provided in paragraphs (e) and (f) of this subsection) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(i) Is a resident, regardless of where the contract owner resides, or

(ii) Is not a resident, but only under both of the following conditions:

1.a. The contract owner of the structured settlement annuity is a resident, or

b. The contract owner of the structured settlement annuity is not a resident, but (A) the insurer that issued the structured settlement annuity is domiciled in this state; and (B) the state in which the contract owner resides has an association similar to the association created by this article; and

2. Neither the payee (or beneficiary) nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(e) This article shall not provide coverage to:

(i) A person who is a payee (or beneficiary) or a contract owner resident of this state, if the payee (or beneficiary) is afforded any coverage by the association of another state;

(ii) A person covered under paragraph (c) of this subsection, if any coverage is provided by the association of another state to the person; or

(iii) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after 26 U.S.C. 5891(c)(3)(A) became effective.

(f) This article is intended to provide coverage to a person who is a resident of this state and in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this article is provided coverage under the laws of any other state, the person shall not be provided coverage under this article. In determining the application of the provisions of this paragraph, in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, enrollee, beneficiary or assignee, this article shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(2)(a) This article shall provide coverage to the persons specified in subsection (1) of this section for policies or contracts of direct, nongroup life insurance, health insurance (which for the purposes of this article includes health maintenance organization subscriber contracts and certificates), or annuities and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this article. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements,

structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

(b) Except as otherwise provided in subsection (3) of this section, this article shall not provide coverage for:

(i) A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

1. Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier; and

2. On and after the date on which the member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or other person under:

1. A Multiple Employer Welfare Arrangement as defined in 29 U.S.C. Section 1002(40);

2. A minimum premium group insurance plan;

3. A stop-loss group insurance plan; or

4. An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

1. Dividends or experience-rating credits;

2. Voting rights; or

3. Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state;

(vii) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty

Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

(viii) A portion of any unallocated annuity contract that is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;

(ix) A portion of a policy or contract to the extent that the assessments required by Section 83-23-217 with respect to the policy or contract are preempted by federal or state law;

(x) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation:

1. Claims based on marketing materials;

2. Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

3. Misrepresentations of or regarding policy or contract benefits;

4. Extra-contractual claims; or

5. A claim for penalties or consequential or incidental damages;

(xi) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(xii) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; and

(xiii) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D), or Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant thereto.

(xiv) Structured settlement annuity benefits to which a payee (or beneficiary) has transferred his or her rights in a structured settlement

factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after 26 U.S.C. 5891(c)(3)(A) became effective.

(3) The exclusion from coverage referenced in subsection (2)(b)(iii) of this section shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.

(4) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b)(i) With respect to any one (1) life, regardless of the number of policies or contracts:

1. Three Hundred Thousand Dollars ($300,000.00) in life insurance death benefits, but not more than One Hundred Thousand Dollars ($100,000.00) in net cash surrender and net cash withdrawal values for life insurance;

2. For health insurance benefits:

a. One Hundred Thousand Dollars ($100,000.00) for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values;

b. Three Hundred Thousand Dollars ($300,000.00) for disability income insurance and Three Hundred Thousand Dollars ($300,000.00) for long-term care insurance;

c. Five Hundred Thousand Dollars ($500,000.00) for health benefit plans;

3. Two Hundred Fifty Thousand Dollars ($250,000.00) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(ii) With respect to each individual participating in a governmental retirement benefit plan established under Section 401, 403(b) or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, Two Hundred Fifty Thousand Dollars ($250,000.00) in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(iii) With respect to each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee if deceased), Two Hundred Fifty Thousand Dollars ($250,000.00) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(iv) However, in no event shall the association be obligated to cover more than (a) an aggregate of Three Hundred Thousand Dollars ($300,000.00) in benefits with respect to any one (1) life under paragraphs (b)(i), (b)(ii) and (b)(iii) of this subsection except with respect to benefits for health benefit plans under paragraph (b)(i) of this subsection, in which

case the aggregate liability of the association shall not exceed Five Hundred Thousand Dollars ($500,000.00) with respect to any one (1) individual, or (b) with respect to one (1) owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than Five Million Dollars ($5,000,000.00) in benefits, regardless of the number of policies and contracts held by the owner;

(v) With respect to either (a) one (1) contract owner provided coverage under subsection (1)(c)(ii) of this section; or (b) one (1) plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in paragraph (b)(ii) of this subsection, Five Million Dollars ($5,000,000.00) in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this article and are owned by a trust or other entity for the benefit of two (2) or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than Five Million Dollars ($5,000,000.00) in benefits with respect to all these unallocated contracts;

(vi) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this article may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(vii) For purposes of this article, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(5) In performing its obligations to provide coverage under Section 83-23-215, the association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

HISTORY: Laws, 1985, ch. 482, § 3; Laws, 1990, ch. 546, § 2; Laws, 1999, ch. 365, § 1; Laws, 2014, ch. 358, § 1, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 2, eff from and after July 1, 2020.

Amendment Notes — The 2014 amendment in (1)(d)(ii)1.b., substituted "(A)" and "(B)" for "(1)" and "(2)"; in (2)(b)(iii), added "or the interest . . . changes in value:" at the

end; in (2)(b)(iii)1. and (2)(b)(iii)2., substituted "member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier" for "association becomes obligated with respect to such policy or contract", in (2)(b)(iii)1., substituted "the" for "a", and "member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier" for "association became obligated"; in (2)(b)(iv)1., substituted "1002(40)" for "1144" at the end; in (2)(b)(x)5., deleted "and" following "incidental damages;" in (2)(b)(xi) and (3)(b)(v), substituted a semicolon for the period at the end of the sentence; and added (2)(b)(xii) and (2)(b)(xiii); in (3)(b)(i)2.a. inserted "or long-term care insurance" and (3)(b)(i)2.b., inserted "and Three Hundred Thousand Dollars ($300,000.00) for long-term care insurance"; and in (3)(b)(i)3., (3)(b)(ii), and (3)(b)(iii), substituted "Two Hundred Fifty Thousand Dollars ($250,000.00)" for "One Hundred Thousand Dollars ($100,000.00)."

The 2020 amendment, in (1), inserted "including health care providers...policies or certificates" in (a), inserted "or enrollees" in the introductory paragraph of (b), inserted "member" in (b)(ii)1, inserted "or health maintenance organization" in (b)(ii)3, added (e)(iii) and made a related change, and inserted "enrollee" in the last sentence of (f); in (2), substituted "for policies or contracts of direct, nongroup life" for "for direct, nongroup life" and inserted "insurance, health insurance...or annuities" thereafter in (a), added the exception at the beginning of (b), inserted "member" in (b)(i), inserted "member" and "enrollee, certificate holder" in (b)(x), inserted "member" and "or contract" in (b)(x)2, inserted "or contract" in (b)(x)3, inserted "or Subchapter XIX...(commonly known as Medicaid)" in (b)(xiii), and added (b)(xiv); added (3), and redesignated former (3) and (4) as (4) and (5); in (4), inserted "member" in (a), substituted "For" for "In" in the introductory language in (b)(i)2, substituted "disability income insurance or health benefit plans or" for "disability insurance or basic hospital medical and surgical insurance or major medical insurance or" in (b)(i)2a, inserted "income" in (b)(i)2b, rewrote (b)(i)2c, which read: "Five Hundred Thousand Dollars ($500,000.00) for basic hospital medical and surgical insurance or major medical insurance," substituted "for health benefit plans" for "for basic health, medical and surgical insurance and major medical insurance" and inserted "or contract," in (b)(iv), and added (b)(vii); in (5), inserted "reissue" and "reissued"; and made minor stylistic changes.

§ 83-23-209. Definitions.

As used in this article:

(a) "Account" means either of the two (2) accounts created under Section 83-23-211.

(b) "Association" means the Mississippi Life and Health Insurance Guaranty Association created under Section 83-23-211.

(c) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(d) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(e) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(f) "Commissioner" means the Commissioner of Insurance of this state.

(g) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 83-23-205.

(h) "Covered contract" or "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Section 83-23-205.

(i) "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys' fees and costs.

(j) "Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include:

(i) Accident only insurance;

(ii) Credit insurance;

(iii) Dental only insurance;

(iv) Vision only insurance;

(v) Medicare Supplement insurance;

(vi) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(vii) Disability income insurance;

(viii) Coverage for on-site medical clinics; or

(ix) Specified disease, hospital confinement indemnity or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(k) "Impaired insurer" means a member insurer which, after April 9, 1985, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(*l*) "Insolvent insurer" means a member insurer which after April 9, 1985, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(m) "Member insurer" means an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this state any kind of insurance or a health maintenance organization business for which coverage is provided under Section 83-23-205, and includes any insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(i) A hospital or medical service organization whether profit or nonprofit;

(ii) A fraternal benefit society;

(iii) A mandatory state pooling plan;

(iv) A mutual assessment company or other person that operates on an assessment basis;

(v) An insurance exchange;

(vi) An organization that has a certificate or license limited to the issuance of charitable gift annuities; or

(vii) An entity similar to any of the above.

(n) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(o) "Owner" of a policy or contract and "policyholder," "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(p) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(q) "Plan sponsor" means:

(i) The employer in the case of a benefit plan established or maintained by a single employer;

(ii) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(iii) In a case of a benefit plan established or maintained by two (2) or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(r) "Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits, and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under Section 83-23-205(2), except that assessable premium shall not be reduced on account of Sections 83-23-205(2)(b)(iii) relating to interest limitations and 83-23-205(3)(b) relating to limitations with respect to one (1) individual, one (1) participant and one (1) policy or contract owner. "Premiums" shall not include:

(i) Premiums in excess of Five Million Dollars ($5,000,000.00) on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code; or

(ii) With respect to multiple nongroup policies of life insurance owned by one (1) owner, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of Five Million Dollars ($5,000,000.00) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(s) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who

establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

The principal place of business of a plan sponsor of a benefit plan described in paragraph (q)(iii) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(t) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer.

(u) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this article, shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

(v) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment

for or with respect to personal injury suffered by the plaintiff or other claimant.

(w) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

(x) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

(y) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

HISTORY: Laws, 1985, ch. 482, § 5; Laws, 1990, ch. 546, § 3; Laws, 1999, ch. 365, § 3; Laws, 2014, ch. 358, § 2, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 3, eff from and after July 1, 2020.

Amendment Notes — The 2014 amendment, in (i), substituted "attorneys'" for "attorney's"; in (l)(iv), deleted "or" from the end; inserted (vii) and redesignated remaining subsections accordingly; in (q), deleted "any" following "does not include" from the beginning of the second sentence.

The 2020 amendment added " 'Covered contract' or" at the beginning of (h) and made a related change; added (j) and redesignated former (j) through (x) as (k) through (y); in (m), inserted "or health maintenance organization" twice and "or a health maintenance organization business" once, deleted former (ii), which read: "A health maintenance organization" and redesignated former (iii) through (viii) as (ii) through (vii), and made a minor stylistic change; in (o), inserted " 'policyholder' " twice and "member" once; in (r), inserted "policy or" in the second sentence of the introductory paragraph, and inserted "or contract" in (ii); substituted "paragraph (q)(iii)" for "paragraph (p)(iii)" in the last paragraph of (s); and inserted "member" in (t) and in the last sentence of (u).

§ 83-23-211. Mississippi Life and Health Insurance Guaranty Association; member insurers; functions; accounts.

(1) There is created a nonprofit legal entity to be known as the Mississippi Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance or a health maintenance organization business in this state. The association shall perform its functions under the plan of operation established and approved under Section 83-23-219 and shall exercise its powers through a board of directors established under Section 83-23-213. For purposes of administration and assessment the association shall maintain two (2) accounts:

(a) The life insurance and annuity account which includes the following subaccounts:

(i) Life insurance account;

(ii) Annuity account which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code, but shall otherwise exclude unallocated annuities; and

(iii) Unallocated annuity account which shall exclude contracts owned by a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code.

(b) The health account.

(2) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

HISTORY: Laws, 1985, ch. 482, § 6; Laws, 1990, ch. 546, § 4; Laws, 1999, ch. 365, § 4, eff from and after passage (approved Mar. 15, 1999); Laws, 2020, ch. 304, § 4, eff from and after July 1, 2020.

Amendment Notes — The 2020 amendment, in (1), inserted "or a health maintenance organization business" in the introductory paragraph, and deleted "insurance" following "The health" in (b).

§ 83-23-215. Powers of association.

(1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, and that are approved by the commissioner:

(a) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, any or all of the policies or contracts of the impaired insurer; or

(b) Provide such monies, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph (a), and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a).

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)1. Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, the policies or contracts of the insolvent insurer; or

2. Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide monies, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the association's duties; or

(b) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

1. With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the

date on which the association becomes obligated with respect to the policies and contracts;

2. With respect to nongroup policies, contracts and annuities not later than the earlier of the next renewal date (if any) under the policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds, enrollees or annuitants (for nongroup policies and contracts), or group policy or contract owners with respect to group policies and contracts, thirty (30) days' notice of the termination (pursuant to subparagraph (i) of this paragraph) of the benefits provided;

(iii) With respect to nongroup policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured, or annuitant, and with respect to an individual formerly an insured, enrollee or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (iv), if the insureds, enrollees or annuitants had a right under law or the terminated policy, contract or annuity to convert coverage to individual coverage or to continue an individual policy, contract or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract or annuity or had a right only to make changes in premium by class;

(iv)1. In providing the substitute coverage required under subparagraph (iii), the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the commissioner;

2. Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract;

3. The association may reinsure any alternative or reissued policy or contract;

(v)1. Alternative policies or contracts adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency;

2. Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten;

3. Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the commissioner;

(vii) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date such coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee or the association;

(viii) When proceeding under subsection (2) of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with Section 83-23-205(2)(b)(iii).

(3) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy, contract or coverage under this article with respect to the policy, contract or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this article.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

(5) The protection provided by this article shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6) In carrying out its duties under subsection (2) of this section, the association may:

(a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this article are less than the amounts needed to assure full and prompt performance of the association's duties under this article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest;

(b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for a period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this state or in a reciprocal state, pursuant to Section 83-24-103 of the Insurers Rehabilitation and Liquidation Act, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to Section 83-24-67 of the Insurers Rehabilitation and Liquidation Act or similar provision of the state of domicile of the impaired or insolvent insurer.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer as provided in subsection (2) of this section, the commissioner shall have the powers and duties of the association under this article with respect to the insolvent insurer.

(9) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of an impaired or insolvent insurer.

(10) The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this article or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and

the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(11)(a) A person receiving benefits under this article shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative policies, contracts or coverages. The association may require an assignment to it of such rights and causes of action by any enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this article upon the person.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this article.

(c) In addition to paragraphs (a) and (b) above, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee or payee of a policy or contract with respect to such policy or contracts (including, without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this article, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefore), excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130.

(d) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts (or portion thereof) covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or contracts (or portion thereof) covered by the association.

(12) In addition to the rights and powers elsewhere in this article, the association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this article;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 83-23-217 and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this article; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this article;

(e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(f) Exercise, for the purposes of this article and to the extent approved by the commissioner, the powers of a domestic life insurer, health insurer or health maintenance organization, but in no case may the association issue policies or contracts other than those issued to perform its obligations under this article;

(g) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(h) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this article with respect to the person, and the person shall promptly comply with the request;

(i) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this article; and

(j) Take other necessary or appropriate action to discharge its duties and obligations under this article or to exercise its powers under this article.

(13) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(14)(a)(i) At any time within one hundred eighty (180) days of the date of the order of liquidation, the association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts or annuities covered, in whole or in part, by the association, in each case under any one or more indemnity reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested to the affected reinsurers.

(ii) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the

financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings.

1. Copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed, and

2. Notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

(iii) The following items 1 through 4 shall apply to reinsurance contracts so assumed by the association:

1. The association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relate to policies, contracts or annuities covered, in whole or in part, by the association. The association may charge policies, contracts or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association and shall provide notice and an accounting of these charges to the liquidator;

2. The association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts or annuities covered, in whole or in part, by the association provided that, upon receipt of any such amounts, the association shall be obliged to pay to the beneficiary under the policy, contract or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

a. The amount received by the association, and

b. The excess of the amount received by the association over the amount equal to the benefits paid by the association on account of the policy, contract or annuity less the retention of the insurer applicable to the loss or event;

3. Within thirty (30) days following the association's election (the "election date"), the association and each reinsurer under contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance contract as of the election date with respect to policies, contracts or annuities covered, in whole or in part, by the association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the association or reinsurer shall pay any remaining

balance due the other, in each case within five (5) days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the association pursuant to subparagraph (iii), the receiver shall remit the same to the association as promptly as practicable;

4. If the association or receiver, on the association's behalf, within sixty (60) days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts or annuities covered, in whole or in part, by the association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premium (insofar as the reinsurance contracts) relate to policies, contracts or annuities covered, in whole or in part, by the association and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association against amounts due the association.

(b) During the period from the date of the order of liquidation until the election date (or, if the election date does not occur, until one hundred eighty (180) days after the date of the order of liquidation).

(i)1. Neither the association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the association has the right to assume under paragraph (a), whether for periods prior to or after the date of the order of liquidation; and

2. The reinsurer, the receiver and the association shall, to the extent practicable, provide each other data and record reasonably requested;

(ii) Provided that once the association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by paragraph (a).

(c) If the association does not elect to assume a reinsurance contract by the election date pursuant to paragraph (a), the association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

(d) When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts or annuities may also be transferred by the association, in the case of contracts assumed under paragraph (a), subject to the following:

(i) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts or annuities in addition to those transferred;

(ii) The obligations described in paragraph (a) of this subsection shall no longer apply with respect to matters arising after the effective date of the transfer; and

(iii) Notice shall be given in writing, return receipt requested, by the

transferring party to the affected reinsurer not less than thirty (30) days prior to the effective date of the transfer.

(e) The provisions of this subsection shall supersede the provisions of any law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation (subject to applicable setoff provisions).

(f) Except as otherwise provided in this subsection, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this subsection shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this subsection shall give a policyholder, contract owner, enrollee, certificate holder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this subsection shall limit or affect the association's rights as a creditor of the estate against the assets of the estate. Nothing in this subsection shall apply to reinsurance agreements covering property or casualty risks.

(15) The board of directors of the association shall have discretion and may exercise a reasonable business judgment to determine the means by which the association is to provide the benefits of this article in an economical and efficient manner.

(16) Where the association has arranged or offered to provide the benefits of this article to a covered person under a plan or arrangement that fulfills the association's obligations under this article, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(17) Venue in a suit against the association arising under the article shall be in Hinds County, Mississippi. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this article.

(18) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsections (1) and (2) of this section, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed interest rate or (ii) payment of dividends with minimum guarantees or (iii) a different method for calculating interest or changes in value;

(b) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

HISTORY: Laws, 1985, ch. 482, § 8; Laws, 1990, ch. 546, § 5; Laws, 1999, ch. 365, § 5; Laws, 2014, ch. 358, § 3, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 5, eff from and after July 1, 2020.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected an error in a statutory reference in the introductory paragraph of (18) by substituting "subsections (1) and (2) of this section" for "Section 83-23-215(1) and (2)." The Joint Committee ratified the correction at its July 24, 2014, meeting.

Amendment Notes — The 2014 amendment, in (4), substituted "If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association." for "and"; in (7), substituted "less the amount" for "and" in the second sentence and "and" for "less the amount" in the last sentence; in (9), substituted "the commissioner's" for "his"; in (11)(a), substituted "A" for "Any"; in (12), added an "s" to "power"; rewrote (14); and added (18).

The 2020 amendment inserted references to "or contract" and "or contracts" throughout; inserted "reissue" and "reissued" in (1)(a) and (2)(a)(i)1; in (2)(b), in (i), deleted "life and health insurance" following "With respect to," substituted "contracts" for "annuities," and deleted "for premiums identical to the premiums and benefits (except for terms of conversion and renewability)" following "assure payment of benefits," in (ii), inserted "enrollees," in (iii), deleted "life and health insurance" following "With respect to nongroup," substituted "contracts" for "annuities," inserted "or health maintenance organization" and inserted references to "enrollee" and "enrollees" throughout, in (iv)1, added "or contract at actuarily...approval of the commissioner," and in (vi), inserted "actuarially justified and" and "or coverage," and substituted "prior approval of the commissioner" for "approval of the domiciliary insurance commissioner and the receivership court"; in (7), substituted "a member insurer" for "an insurer"; in (10), inserted "reissuing"; in (11), inserted "policies, contracts or" in (a), and "enrollee" in (a) and (c); in (12), in (f), substituted "domestic life insurer, health insurer or health maintenance organization" for "domestic life or health insurer" and "issue policies or contracts" for "issue insurance policies or annuity contracts," added (i), redesignated former (i) as (j), and made related and stylistic changes; in (14), in (a)(i), inserted "in each case," in (a)(iii)1, rewrote the first sentence, which read: "The association shall be responsible for all unpaid premiums due under the reinsurance contracts (for periods both before and after the date of the order of liquidation), and shall be responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to contracts covered (in whole or in part) by the association," in (a)(iii)3, inserted "member" in the first sentence and substituted "subparagraph (iii)" for "subparagraph (ii)" in the last sentence, in (a)(iii)4, inserted "on the association's behalf," and in (f), inserted "contract owner, enrollee, certificate holder"; in (18), inserted "reissuing," and deleted "subject to approval of the receivership court" following "association may" and made stylistic and punctuation changes throughout.

§ 83-23-217. Assessments against member insurers; classes; refunds; treatment of assessments on financial statements of member insurers; protest of assessment.

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such

amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(2) There shall be two (2) classes of assessments, as follows:

(a) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under Section 83-23-215 with regard to an impaired or insolvent insurer.

(3)(a) The amount of a Class A assessment shall be determined by the board and may be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. The total of all nonpro rata assessments shall not exceed Five Hundred Dollars ($500.00) per member insurer in any one (1) calendar year.

(b) The amount of a Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(c) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology shall provide for fifty percent (50%) of the assessment to be allocated to accident and health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

(d) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became insolvent (or, in the case of an assessment with respect to an impaired insurer, the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became impaired) bears to premiums received on business in this state for those calendar years by all assessed member insurers.

(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this article. Classification of assessments under subsection (2) and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata

share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a)(i) Subject to the provisions of subparagraph (ii) of this paragraph, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in one (1) calendar year exceed two percent (2%) of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three (3) calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

(ii) If two (2) or more assessments are authorized in one (1) calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subparagraph (i) of this paragraph shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(iii) If the maximum assessment, together with the other assets of the association in an account, does not provide in one (1) year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(c) If the maximum assessment for a subaccount of the life and annuity account in one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection (3)(b) of this section, the board shall assess the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection (5)(a) above.

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account

exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to the account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses claims.

(7) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this article, to consider the amount reasonably necessary to meet its assessment obligations under this article.

(8) The association shall issue to each member insurer paying an assessment under this article, other than a Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

(9)(a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

HISTORY: Laws, 1985, ch. 482, § 9; Laws, 1990, ch. 546, § 6; Laws, 1999, ch. 365, § 6; Laws, 2014, ch. 358, § 4, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 6, eff from and after July 1, 2020.

Amendment Notes — The 2014 amendment, in (3)(a), substituted "Three Hundred Dollars ($300.00)" for "One Hundred Fifty Dollars ($150.00)"; in (3)(b), deleted "such" following "insurer became impaired) bears to", and substituted "those" for "such"; and in (4), substituted "the" for "such."

The 2020 amendment, in (3), in (a), substituted "a Class A" for "any Class A," substituted "Five Hundred Dollars ($500.00)" for "Three Hundred Dollars ($300.00)," and deleted the former last sentence, which read: "The amount of a Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances," added (b) and (c), redesignated former (b) and (c) as (d) and (e), and in (d), inserted "member" the third and fourth time it appears; in (5)(a), inserted "member" near the end of (i) and in (ii); in (6), inserted "member"; in (7), inserted "or health maintenance organization business"; in (8), inserted "member" twice; in (9)(e), substituted "member insurer" for "member company" and inserted "insurer" in the last sentence; and made punctuation and minor stylistic changes throughout.

§ 83-23-219. Plan of operation; approval by commissioner; contents of plan.

(1)(a) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or unless it has not been disapproved within thirty (30) days.

(b) If the association fails to submit a suitable plan of operation within one hundred eighty (180) days following April 9, 1985, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this article. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this article:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under Section 83-23-213;

(c) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;

(f) Establish any additional procedures for assessments under Section 83-23-217;

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association;

(h) Establish procedures whereby a director may be removed for cause, including in the case where a member insurer director becomes an impaired or insolvent insurer;

(i) Require the board of directors to establish a policy and procedures for addressing conflicts of interests.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under Sections 83-23-215 and 83-23-217, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this article.

HISTORY: Laws, 1985, ch. 482, § 10; Laws, 1990, ch. 546, § 7; Laws, 2014, ch. 358, § 5, eff from and after passage (approved Mar. 17, 2014).

Amendment Notes — The 2014 amendment, in (1)(a), substituted "it has not been disapproved within thirty (30) days" for "he has not disapproved it within thirty (30) days"; and added (3)(h) and (3)(i).

§ 83-23-221. Duties of commissioner; enforcement of assessments against member insurers; appeal.

(1) In addition to the duties and powers enumerated elsewhere in this article, the commissioner shall:

(a) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer; and

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the impaired insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this article.

(2) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. The forfeiture

shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than One Hundred Dollars ($100.00) per month.

(3) A final action of the board of directors or the association may be appealed to the commissioner by a member insurer if the appeal is taken within sixty (60) days of its receipt of notice of the final action being appealed. A final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

(4) The liquidator, rehabilitator or conservator of an impaired or insolvent insurer may notify all interested persons of the effect of this article.

HISTORY: Laws, 1985, ch. 482, § 11; Laws, 1990, ch. 546, § 8; Laws, 1999, ch. 365, § 7; Laws, 2014, ch. 358, § 6, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 7, eff from and after July 1, 2020.

Amendment Notes — The 2014 amendment deleted (1)(c), which read: "In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator"; in (2), substituted "The" for "Such"; in (3), substituted "a" for "any", "the" for "such", and "sixty (60)" for "thirty (30)"; in (4), substituted "an" for "any," and inserted "or insolvent."

The 2020 amendment inserted "impaired" in (1)(b); and substituted "transact business in this state" for "transact insurance in this state" in (2).

§ 83-23-223. Detection and prevention of member insurer insolvencies or impairments.

To aid in the detection and prevention of member insurer insolvencies or impairments:

(1) It shall be the duty of the commissioner;

(a) To notify the commissioners of all the other states, territories of the United States and the District of Columbia within thirty (30) days following the action taken or the date the action occurs, when the commissioner takes any of the following actions against a member insurer:

(i) Revocation of license;

(ii) Suspension of license; or

(iii) Makes a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus or any other account for the security of policy owners, contract owners, certificate holders or creditors.

(b) To report to the board of directors when the commissioner has taken any of the actions set forth in subparagraph (a) or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(c) To report to the board of directors when the commissioner has reasonable cause to believe from an examination, whether completed or in

process, of any member insurer that the insurer may be an impaired or insolvent insurer.

(d) To furnish to the board of directors the NAIC Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

(2) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the commissioner regarding the financial condition of member insurers and insurers or health maintenance organizations seeking admission to transact business in this state.

(3) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any insurer or health maintenance organization seeking to do business in this state. The reports and recommendations shall not be considered public documents.

(4) The board of directors may, upon majority vote, notify the commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

(5) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

HISTORY: Laws, 1985, ch. 482, § 12; Laws, 1999, ch. 365, § 8; Laws, 2014, ch. 358, § 7, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 8, eff from and after July 1, 2020.

Amendment Notes — The 2014 amendment, in (1)(a)(iii), substituted "the" for "such"; in (1)(b), deleted "of this paragraph" following "actions set forth in"; in (1)(c), substituted "an" for "any"; inserted "Insurance Regulatory Information System (IRIS)" in (1)(d); and in (4), substituted "a" for "any."

The 2020 amendment inserted "member" in the introductory paragraph; in (1)(a)(iii), substituted "member insurer" for "company," and inserted "contract owners, certificate holders"; in (2), substituted "insurers or health maintenance organizations seeking" for "companies seeking," and deleted "insurance" preceding "business in this state"; in (3), substituted "insurer or health maintenance organization seeking" for "company seeking," and deleted "an insurance" preceding "business in this state"; and in (5), inserted "member."

§ 83-23-225. Liability of insolvent or impaired insurer for assessments.

(1) This article shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under Section 83-23-215. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, except (a) upon the termination of the impairment or insolvency of the member insurer, or (b) upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under Section 83-23-227.

(3) For the purpose of carrying out its obligations under this article, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to Section 83-23-215(11). Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this article. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

(4) As a creditor of the impaired or insolvent insurer as established in subsection (3) of this section and consistent with Section 83-24-67, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this article. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(5)(a) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, contract owners, certificate holders, enrollees and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners, contract owners, certificate holders and enrollees of the continuing or successor member insurer.

(b) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under Section 83-23-215 with respect to the member insurer have been fully recovered by the association.

(6)(a) If an order for liquidation or rehabilitation of a member insurer domiciled in this state has been entered, the receiver appointed under the order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (b) through (d).

(b) No such distribution shall be recoverable if the member insurer shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared, shall be liable up to the amount of distributions which would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(e) If any person liable under paragraph (c) is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

HISTORY: Laws, 1985, ch. 482, § 13; Laws, 1990, ch. 546, § 9; Laws, 1999, ch. 365, § 9; Laws, 2014, ch. 358, § 8, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 9, eff from and after July 1, 2020.

Amendment Notes — The 2014 amendment, in (2), inserted "except (a)" and "(b)"; in (6)(a), substituted "the order " for "such order"; in (6)(c), deleted "he" following "liable up to the amount of distributions", substituted "which would have been" for "he would have."

The 2020 amendment, in (2), inserted "member" in the second sentence; in (3), inserted "or contracts" and "or health benefit plans" in the last sentence; in (4), substituted "insolvency of a member insurer" for "insolvency of an insurer"; in (5), in (a), inserted "contract owners, certificate holders, enrollees" twice and "member," and in (b), substituted "the member insurer" for "such insurer"; and in (6), inserted "member" everywhere it appears in (a) through (c), and made a related change in (a).

§ 83-23-227. Regulation by commissioner; annual report.

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, each year not later than one hundred twenty (120) days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year. Upon the request of a member

insurer, the association shall provide the member insurer with a copy of the report.

HISTORY: Laws, 1985, ch. 482, § 14; Laws, 2014, ch. 358, § 9, eff from and after passage (approved Mar. 17, 2014).

Amendment Notes — The 2014 amendment, rewrote the second sentence and added the third sentence.

§ 83-23-233. Stay of judicial proceedings upon order of liquidation, rehabilitation, or conservation.

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed one hundred and eighty (180) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

HISTORY: Laws, 1985, ch. 482, § 17; Laws, 2014, ch. 358, § 10, eff from and after passage (approved Mar. 17, 2014).

Amendment Notes — The 2014 amendment, in the first sentence, substituted "one hundred and eighty (180)" for "sixty (60)" and "or duties" for "and duties."

§ 83-23-235. Use of association's name in insurance advertisements or solicitations; association to prepare document describing general purposes and limitations of association.

(1) No person, including a member insurer, agent or affiliate of a member insurer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the Insurance Guaranty Association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance or other coverage covered by the Mississippi Life and Health Insurance Guaranty Association Act. However, this section shall not apply to the Mississippi Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

(2) Within one hundred eighty (180) days of April 9, 1985, the association shall prepare a summary document describing the general purposes and current limitations of the article and complying with subsection (3) of this section. This document shall be submitted to the commissioner for approval. At

the expiration of the sixtieth day after the date on which the commissioner approves the document, a member insurer may not deliver a policy or contract to a policy owner, contract owner, certificate holder or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder or enrollee at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner, contract owner, certificate holder or enrollee. The distribution, delivery or contents or interpretation of this document does not guarantee that either the policy or the contract or the policy owner, contract owner, certificate holder or enrollee is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the article may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee or insured any greater rights than those stated in this article.

(3) The document prepared under subsection (2) shall contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer shall:

(a) State the name and address of the Life and Health Insurance Guaranty Association and insurance department;

(b) Prominently warn the policy owner, contract owner, certificate holder or enrollee that the Life and Health Insurance Guaranty Association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this state;

(c) State the types of policies or contracts for which guaranty funds will provide coverage;

(d) State that the member insurer and its agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance or health maintenance organization coverage;

(e) State that the policy owner, contract owner, certificate holder or enrollee should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer or health maintenance organization;

(f) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this article; and

(g) Provide other information as directed by the commissioner including, but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under that state's public records law.

(4) A member insurer shall retain evidence of compliance with subsection (2) for so long as the policy or contract for which the notice is given remains in effect.

HISTORY: Laws, 1985, ch. 482, § 18; Laws, 1999, ch. 365, § 10, eff from and after passage (approved Mar. 15, 1999); Laws, 2020, ch. 304, § 10, eff from and after July 1, 2020.

Amendment Notes — The 2020 amendment inserted "member" and made related changes throughout; in (1), inserted "or other coverage" in the next-to-last sentence, and added "or coverage by a health maintenance organization" at the end; in (2), inserted "owner" twice and "certificate holder or enrollee" twice in the third sentence, inserted "contract owner, certificate holder or enrollee" in the fourth sentence, substituted "policy owner, contract owner, certificate holder or enrollee is covered" for "owner of the policy or contract is covered" in the fifth sentence, and inserted "enrollee" in the last sentence; and in (3), in (b), substituted "policy owner" for "policy or" and inserted "certificate holder or enrollee" and "or contract," in (c), inserted "or contracts," in (d), inserted "member" and added "or health maintenance organization coverage," in (e), substituted "policy owner" for "policy or," inserted "certificate holder or enrollee" and added "or health maintenance organization."

§ 83-23-237. Applicability of amendments by Chapter 358, Laws of 2014.

The amendments made to this article by this act during the 2014 Regular Session of the Legislature shall not apply to any member insurer that, before March 17, 2014, has been placed under an order of liquidation with a finding of insolvency.

HISTORY: Laws, 2014, ch. 358, § 11, eff from and after passage (approved Mar. 17, 2014).

Editor's Notes — Chapter 358, Laws of 2014, amended the following: Sections 83-23-205, 83-23-209, 83-23-215, 83-23-217, 83-23-219, 83-23-221, 83-23-223, 83-23-225, 83-23-227, 83-23-233, and 83-23-239.

§ 83-23-239. Amendments by Chapter 304, Laws of 2020, to this article not applicable to member insurers placed under liquidation order.

The amendments made to this article by Chapter 304, Laws of 2020, shall not apply to any member insurer that, before the effective date of those amendments, has been placed under an order of liquidation with a finding of insolvency.

HISTORY: Laws, 2020, ch. 304, § 11, eff from and after July 1, 2020.

CHAPTER 29.

FRATERNAL SOCIETIES

Sec.
83-29-45. Examination of domestic societies.

§ 83-29-45. Examination of domestic societies.

The Commissioner of Insurance, or any person or persons he may appoint, shall have the power of visitation and examination into the affairs of any domestic society. They shall have free access to all the books, papers, and documents that relate to the business of the society.

The expenses of such examination shall be paid by the society examined, upon statement furnished by the Commissioner of Insurance, and the examination shall be made as often as the commissioner, in his sole discretion, deems appropriate but, at a minimum, at least once in every five (5) years.

Whenever after examination the Commissioner of Insurance is satisfied that any domestic society has failed to comply with any provisions of this chapter, or is exceeding its powers, or is not carrying out its contracts in good faith, or is transacting business fraudulently, or whenever any domestic society, after the existence of one (1) year or more, shall have a membership of less than four hundred (400) or shall determine to discontinue business, the Commissioner of Insurance may present the facts relating thereto to the Attorney General, who shall, if he deem the circumstances warrant, commence an action in quo warranto in a court of competent jurisdiction. Such court shall thereupon notify the officers of such society of a hearing, and if it shall then appear that such society should be closed, said society shall be enjoined from carrying on any further business; and some person shall be appointed receiver of such society and shall proceed at once to take possession of the books, papers, monies, and other assets of the society and shall forthwith, under the direction of the court, proceed to close the affairs of the society and to distribute its funds to those entitled thereto.

HISTORY: Codes, 1930, § 5253; 1942, § 5767; Laws, 2012, ch. 364, § 2, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment rewrote the second paragraph.

CHAPTER 33.

RECIPROCAL INSURANCE

Sec.

83-33-1. Regulation of exchange.
83-33-3. Execution of contracts.
83-33-5. Declaration under oath.
83-33-7. Commissioner as agent for service of process; reciprocal may sue or be sued in its own name; prohibition against suing subscribers.
83-33-11. Assets maintained.
83-33-13. Financial reports.
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83-33-19. Taxation of premium receipts.
83-33-21. Subscriber's agreement and power of attorney.
83-33-23. Board of directors to control and manage reciprocal.
83-33-25. Return of savings or credits accruing to subscribers.
83-33-27. Certificate to issue nonassessable policies of insurance.
83-33-29. Issuing nonassessable policies without obtaining certificate of nonassessability prohibited; contingent assessment liability.
83-33-31. Computation and timing of assessments levied against subscribers.
83-33-33. Liability of subscribers for reciprocal's debts or obligations.
83-33-35. Applicability of licensing requirements and regulations to employees and agents of reciprocal and its attorney.

Sec.
83-33-37. Two or more reciprocals authorized to combine assets and liabilities into one reciprocal.

§ 83-33-1. Regulation of exchange.

Individuals, partnerships, corporations, limited liability companies, public hospitals, including community hospitals, and all other types of entities authorized to exist under the laws of this state, designated as subscribers, may exchange reciprocal or inter insurance contracts with each other or with individuals and all types of entities authorized to exist under the laws of other states, territories, districts and countries, providing insurance or indemnity among themselves from any loss which may be insured against under other provisions of the law except life insurance.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209t; 1930, § 5291; 1942, § 5805; Laws, 1918, ch. 190; Laws, 1995, ch. 313, § 1; Laws, 2013, ch. 459, § 1, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment inserted "limited liability companies . . . under the laws"; substituted "individuals and all types . . . other states, territories, districts and counties" for "individuals, partnerships and corporations of other states and counties"; inserted "insurance or"; and made related minor stylistic changes.

§ 83-33-3. Execution of contracts.

Such contracts may be executed by an attorney, agent, or other representative, herein designated attorney, duly authorized and acting for said subscribers, and such attorney may be a corporation or limited liability company. The office or offices of such attorney may be maintained at such place or places as may be designated by the subscribers in the power of attorney.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209u; 1930, § 5292; 1942, § 5806; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 2, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment added "or limited liability company" at the end of the first sentence.

§ 83-33-5. Declaration under oath.

Such subscribers so contracting among themselves shall, through their attorney, file with the Commissioner of Insurance a declaration verified by the oath of such attorney or, where such attorney is a corporation, by the oath of the proper officer thereof, setting forth:

(a) The name of the reciprocal, which name shall not be so similar to any name adopted by any insurance organization authorized to write the same class of insurance in this state as to confuse or deceive.

(b) The address of the reciprocal's principal office;

(c) The name of the attorney and address of its principal office;

(d) The kind or kinds of insurance to be effected or exchanged.

(e) A copy of the form of policy contract or agreement under or by which such insurance is to be effected or exchanged.

(f) A copy of the form of power of attorney or other authority of such attorney under which such insurance is to be effected or exchanged.

(g) The location of office or offices from which such contracts or agreements are to be issued.

(h) That applications have been made for indemnity upon at least ten (10) separate risks aggregating not less than One Million Five Hundred Thousand Dollars ($1,500,000.00), as represented by executed contracts or bona fide applications to become concurrently effective; or in case of employers' liability or similar classes of insurance, covering a total payroll of not less than Two Million Five Hundred Thousand Dollars ($2,500,000.00).

(i) That there is in the possession of such attorney and available for the payment of losses, assets conforming to Section 83-33-11.

(j) A financial statement in form prescribed for the annual statement.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209v; 1930, § 5293; 1942, § 5807; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 3, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment substituted "Commissioner of Revenue" for "Insurance Commissioner" in the introductory paragraph; rewrote (a), which formerly read: "The name of the attorney and the name or designation under which such contracts are issued, which name or designation shall not be so similar to any name or designation adopted by any attorney or by an insurance organization in the United States writing the same class of insurance prior to the adoption of such name or designation by the attorney as to confuse of deceive"; added (b) and (c) and redesignated former (b) through (h) as (d) through (j); and substituted "ten (10)" for "seventy-five (75)" in (h).

§ 83-33-7. Commissioner as agent for service of process; reciprocal may sue or be sued in its own name; prohibition against suing subscribers.

Any reciprocal doing business in this state may sue or be sued in its name as set forth in its certificate of authority or license. Concurrently with the filing of the declaration provided by the terms of Section 83-33-5, the attorney shall file with the Commissioner of Insurance an instrument in writing, executed by him for said subscribers, conditioned that upon the issuance of certificates of authority provided in Section 83-33-17 action may be brought in the county in which the property or person insured thereunder is located, and service of process may be had upon the Commissioner of Insurance in all suits in this state arising out of such policies, contracts, or agreements, which service shall be valid and binding upon the reciprocal. Three (3) copies of each process shall be served, and the Insurance Department shall file one (1) copy, forward one (1) copy to said attorney, and return one (1) copy with his admission of service. All suits of every kind and description brought against such reciprocal must be brought against the reciprocal as such, and shall not and may not be brought

against any of the subscribers thereto individually on account of their connection with or membership in such reciprocal, and must be brought in the manner and method above provided. A judgment rendered in any such case where service of process has been so had upon the Commissioner of Insurance shall be valid and binding against the reciprocal, and such judgment may only be satisfied solely out of the funds of the reciprocal.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209w; 1930, § 5294; 1942, § 5808; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 4, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment added the first sentence; substituted "Commissioner of Insurance" for "Insurance Commissioner" everywhere it appears; substituted "valid and binding upon the reciprocal" for "valid and binding upon all subscribers exchanging at any time the reciprocal or inter-insurance contracts through such attorney"; substituted "Insurance Department" for "insurance commission"; added the fourth sentence; and substituted "binding against the reciprocal, and such judgment may only be satisfied solely out of the funds of the reciprocal" for "binding against any and all such subscribers as their interests appear, and such judgment may be satisfied out of the funds in the possession of the attorney belonging to such subscribers."

§ 83-33-11. Assets maintained.

(1) There shall be maintained at all times assets in cash or securities authorized by the laws of this state for the investment of funds of insurance companies doing the same kind of business, an amount equal to one hundred percent (100%) of the unearned premiums or deposits collected and credited to the accounts of subscribers, or fifty percent (50%) of the advance premiums or deposits collected and credited to the accounts of subscribers on policies having one (1) year or less to run, pro rata on those for longer periods. In addition to the foregoing sum in the case of liability insurance, there shall be maintained as a reserve assets sufficient to discharge all liabilities on all outstanding claims, both reported and incurred but not reported, arising under all policies issued, the same to be calculated on the basis of premiums or deposits as in this section defined and in accordance with the laws of the state relating to similar reserves for companies insuring similar risks. Premiums or deposits as used in this section shall be construed to mean the advance payments made by subscribers. If at any time the assets on hand are less than the foregoing requirements or less than One Hundred Thousand Dollars ($100,000.00), whichever is the greater, where the attorney is exchanging contracts covering employers' liability or similar classes of insurance, the reciprocal shall make up the deficiency. Whenever such assets are less than the amount above required or less than Fifty Thousand Dollars ($50,000.00), whichever is the greater, if the attorney is exchanging contracts other than those covering employers' liability or similar classes of insurance, the reciprocal shall make up the deficiency.

(2) Notwithstanding subsection (1) of this section, a reciprocal authorized to transact business under this chapter shall comply with the minimum

capital, surplus and reserve requirements of a stock company writing similar lines of insurance.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209y; 1930, § 5296; 1942, § 5810; Laws, 1918, ch. 190; Laws, 1995, ch. 313, § 2; Laws, 2013, ch. 459, § 5, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment substituted "reciprocal" for "subscriber" in the last two sentences of (1); and rewrote (2), which formerly read: "Reserve requirements are determined in accordance with those of similar companies insuring similar risks."

§ 83-33-13. Financial reports.

Such reciprocal shall, within the time limited for filing the annual report by insurance companies transacting the same kind of business, make a report to the Commissioner of Insurance for each calendar year showing the financial condition of affairs at the office where such contracts are issued, and shall furnish such additional information and reports as may be required to show the total premiums or deposits collected, the total losses paid, the total amounts returned to subscribers, and the amounts retained for expenses, provided, however, that such reciprocal shall not be required to furnish the names and addresses of any subscribers. The business affairs and assets of such organization shall be subject to examination by the Commissioner of Insurance at the expense of the office examined.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209z; 1930, § 5297; 1942, § 5811; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 6, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment substituted "reciprocal" for "attorney" and substituted "Commissioner of Insurance" for "Insurance Commissioner" everywhere the terms appear.

§ 83-33-15. Penalty.

Any attorney who shall exchange any contracts of insurance of the kind and character specified in this chapter or any attorney or representative of such attorney who shall solicit or negotiate any application for same without the attorney first complying with the foregoing provisions shall be deemed guilty of a misdemeanor and, on conviction thereof, shall be subjected to a fine of not less than One Hundred Dollars ($100.00) nor more than One Thousand Dollars ($1,000.00). For the purpose of organization and upon issuance of permit by the Commissioner of Insurance, powers of attorney may be solicited without license; but no attorney, agent, or other persons shall effect any such contracts of insurance until all the provisions of this chapter shall have been complied with.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209a1; 1930, § 5298; 1942, § 5812; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 7, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment substituted "Commissioner of Insurance" for "Insurance Commissioner" in the last sentence.

§ 83-33-17. Certificate of authority.

Upon compliance with the foregoing requirements and the payment of the fees and taxes provided in this chapter, the Commissioner of Insurance shall issue a certificate of authority to the reciprocal. The Commissioner of Insurance may revoke or suspend any certificate of authority issued hereunder in case of breach of any of the conditions imposed by this chapter after reasonable notice has been given to the reciprocal in writing, so that the reciprocal may appear and show cause why such action should not be taken. Any reciprocal who may have procured a certificate of authority hereunder may have the same renewed annually thereafter, provided that any certificate of authority issued shall continue in force and effect until a new certificate of authority is issued or specifically refused.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209b1; 1930, § 5299; 1942, § 5813; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 8, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment substituted "Commissioner of Insurance" for "insurance commissioner" everywhere it appears; substituted "reciprocal" for references to "he" and "attorney" throughout the section; and made a minor stylistic insertion.

§ 83-33-19. Taxation of premium receipts.

Such reciprocal shall upon the issuance of the certificate of authority herein provided pay to the state the sum of Two Hundred Dollars ($200.00), as provided in Section 27-15-83, and with the filing of the annual report herein provided shall pay an annual tax upon the gross premiums or deposits collected from subscribers in this state during the preceding calendar year, after deducting therefrom returns for cancellations, considerations for reinsurance, and all amounts returned to subscribers or credited to their account as savings, as provided in Section 27-15-103 et seq.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209c1; 1930, § 5300; 1942, § 5814; Laws, 1918, ch. 190; Laws, 1978, ch. 441, § 6; Laws, 2013, ch. 459, § 9, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment deleted "attorney" preceding "reciprocal shall upon the issuance."

§ 83-33-21. Subscriber's agreement and power of attorney.

(1) Every subscriber of a domestic reciprocal may execute a subscriber's agreement and power of attorney setting forth the rights, privileges and obligations of the subscriber as an underwriter and as a policyholder, and the powers and duties of the attorney and reciprocal.

(2) If a domestic reciprocal requires execution of a subscriber's agreement and power of attorney by a subscriber, then the subscriber, by its execution, shall be bound by the terms and conditions of the subscriber's agreement and power of attorney.

(3) If a domestic reciprocal does not require execution of a subscriber's agreement and power of attorney, the reciprocal shall include on its policies a statement that the subscriber shall be bound by the terms and conditions of the then current subscriber's agreement and power of attorney on file with and as approved by the Commissioner of Insurance, and each subscriber shall by operation of law be bound by such subscriber's agreement and power of attorney as if individually executed by such subscriber. Without additional execution, notice or acceptance, every subscriber of a reciprocal agrees to be bound by any modification of the terms of the subscriber's agreement and power of attorney which is jointly made by the attorney and the board of directors and amendments thereto, which shall be on file with the attorney and Commissioner of Insurance, which shall become effective upon its approval by the Commissioner of Insurance, and which shall by operation of law bind all subscribers the same as if each subscriber adopted and executed the modified subscriber's agreement and power of attorney. No such modification shall be effective retroactively, nor shall it affect any insurance contract issued prior to the modification. The Commissioner of Insurance's approval shall be deemed given if the subscriber's agreement and power of attorney or any amendment is not disapproved within thirty (30) days of its filing.

HISTORY: Laws, 2013, ch. 459, § 10, eff from and after July 1, 2013.

§ 83-33-23. Board of directors to control and manage reciprocal.

The board of directors for the reciprocal shall have and exercise the ultimate power over the control and management of the affairs of the reciprocal, subject to the subscriber's agreement. The board of directors shall be selected under rules adopted by the subscribers. At least two-thirds (⅔) of the board of directors of a domestic reciprocal shall be composed of subscribers or representatives of subscribers, other than the attorney or any person employed by or having a financial interest in the attorney. An individual shall not be considered to be employed by or having a financial interest in the attorney if such individual is a subscriber or a representative of a subscriber of the reciprocal. The board of directors may also be referred to as a subscribers advisory committee, board of trustees or by such other name as the board chooses.

HISTORY: Laws, 2013, ch. 459, § 11, eff from and after July 1, 2013.

§ 83-33-25. Return of savings or credits accruing to subscribers.

A reciprocal may return to its subscribers any savings or credits accruing to their accounts.

HISTORY: Laws, 2013, ch. 459, § 12, eff from and after July 1, 2013.

§ 83-33-27. Certificate to issue nonassessable policies of insurance.

(1) A domestic reciprocal insurer may apply for a certificate to issue nonassessable policies of insurance. A nonassessable policy is a policy in which a subscriber may not be assessed pursuant to Sections 83-33-29 and 83-33-31. If a domestic reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital and surplus required to be maintained by a domestic stock insurer authorized to transact like kinds of insurance, upon application by the domestic reciprocal insurer the Commissioner of Insurance shall issue a certificate of nonassessability authorizing the insurer to omit provisions imposing contingent assessment liability in all policies delivered or issued or renewed.

(2) If a domestic reciprocal insurer's surplus of assets over all liabilities falls below the minimum capital and surplus required to be maintained by a domestic stock insurer authorized to transact like kinds of insurance, the Commissioner of Insurance may forthwith revoke the certificate of nonassessability. The revocation shall not render subject to contingent assessment liability any policy then in force.

HISTORY: Laws, 2013, ch. 459, § 13, eff from and after July 1, 2013.

Cross References — Reciprocals prohibited from issuing nonassessable policies unless issued a certificate of nonassessability pursuant to this section, see § 83-33-29.

§ 83-33-29. Issuing nonassessable policies without obtaining certificate of nonassessability prohibited; contingent assessment liability.

(1) Any domestic reciprocal insurer that has not been issued a certificate allowing it to issue nonassessable policies as provided in Section 83-33-27 shall issue assessable policies. An assessable policy is a policy in which the insurer charges an initial premium but may later charge an additional premium in accordance with the provisions of this section and Section 83-33-31.

(2) The contingent assessment liability on any one (1) policy in any one (1) calendar year shall equal the premiums earned on the policy for that year multiplied by not less than one (1) nor more than ten (10) as set forth in the policy.

(3) The contingent assessment liability shall not be joint, but shall be individual and several.

(4) Each assessable policy issued by the insurer shall plainly set forth a statement of the contingent assessment liability on the front of the policy in capital letters in not less than ten point type.

HISTORY: Laws, 2013, ch. 459, § 14, eff from and after July 1, 2013.

§ 83-33-31. Computation and timing of assessments levied against subscribers.

(1) Assessments may be levied against the subscribers of a domestic assessable reciprocal in accordance with Section 83-33-29.

(2) Any assessment levied against the subscribers of a domestic assessable reciprocal shall treat all subscribers equally in that each subscriber's assessment shall be at the same multiple of the subscriber's policies' individual earned premium for the period covered by the assessment. However, no assessment shall exceed the aggregate contingent assessment liability computed in accordance with Section 83-33-29. For the purposes of this section, the premiums earned on the subscriber's policies are the gross premiums charged by the reciprocal for the policies, minus any charges not recurring upon the renewal or extension of the policies. No subscriber shall have an offset against any assessment for which the subscriber is liable on account of any claim for unearned premium or losses payable.

(3) Every subscriber of a domestic reciprocal having contingent assessment liability shall be liable for and shall pay the subscriber's share of any assessment computed in accordance with this section if, while such policy is in force, or within three (3) years after its termination, the subscriber is notified:

(a) By the reciprocal or the attorney of the reciprocal's intention to levy an assessment; or

(b) That delinquency proceedings have been instituted against the reciprocal under this title and the department or receiver intends to levy an assessment.

HISTORY: Laws, 2013, ch. 459, § 15, eff from and after July 1, 2013.

§ 83-33-33. Liability of subscribers for reciprocal's debts or obligations.

No subscriber of a reciprocal shall be personally liable for the payment of the reciprocal's debts or obligations. Any judgment obtained against a reciprocal shall be binding and enforceable only upon and against the reciprocal and shall not be binding or enforceable upon or against any of the reciprocal's subscribers. No legal action shall be allowed to be brought or maintained against the subscribers or insureds of a reciprocal for the payment of the reciprocal's debts or obligations; provided, however, nothing in this section shall diminish or eliminate a subscriber's contingent assessment liability under an assessable policy as provided in Sections 83-33-29 and 83-33-31.

HISTORY: Laws, 2013, ch. 459, § 16, eff from and after July 1, 2013.

§ 83-33-35. Applicability of licensing requirements and regulations to employees and agents of reciprocal and its attorney.

The provisions of this code regarding the appointment, licensing, qualifi-

cation and regulation of insurance agents, brokers and solicitors, do not apply to the reciprocal or its attorney, nor to the salaried representatives of such reciprocal or attorney who receive no commissions, but do apply in the case of any agent, broker or solicitor of any reciprocal who receives any commission.

HISTORY: Laws, 2013, ch. 459, § 17, eff from and after July 1, 2013.

§ 83-33-37. Two or more reciprocals authorized to combine assets and liabilities into one reciprocal.

Two (2) or more reciprocals may combine their assets and liabilities into one (1) reciprocal, subject to the approval of the Commissioner of Insurance.

HISTORY: Laws, 2013, ch. 459, § 18, eff from and after July 1, 2013.

CHAPTER 34.

WINDSTORM UNDERWRITING ASSOCIATION

Sec.

83-34-1. Definitions.

83-34-3. Creation of Mississippi Windstorm Underwriting Association; organizational structure; certain licensed insurers to become assessable insurers; association revenues; association not subject to state bid requirements.

83-34-4. Nonadmitted policy fee; responsibility of surplus lines insurance producer placing insurance through nonadmitted insurer to collect and remit fees; calculation of fee; penalty for nonpayment [Repealed effective July 1, 2022].

83-34-5. Powers and duties.

83-34-9. Participation by assessable insurers in recoupable and nonrecoupable assessments levied by association; financial incentives and/or penalties to ensure assessable insurers write insurance in the coast area.

83-34-10. Power to levy recoupable and nonrecoupable assessments upon occurrence of certain events; maximum nonrecoupable assessments.

83-34-11. Repealed.

83-34-12. Deferment of assessable insurer's recoupable or nonrecoupable assessment; amount deferred to be assessed against other assessable insurers.

83-34-13. Plan of operation; contents; approval by commissioner; certification of approval; effective date of plan.

83-34-23. Immunity from liability.

83-34-31. Powers and authority of board of directors to issue bonds and enter into loans or other forms of indebtedness; rights and remedies of bondholders not to be impaired.

83-34-33. Surcharge for excess covered event losses on all property and casualty premiums; issuance of bonds to pay claims losses; exempted premiums; purpose of certain surcharges to be designated and specifically identified; licensed insurers and agents to collect and remit surcharges; setting and adjustment of surcharge percentage; cessation of surcharge.

83-34-35. Commissioner to approve association rates at least adequate to fund annual reinsurance above a certain reserve.

§ 83-34-1. Definitions.

In this chapter, unless the context otherwise requires:

(a) "Essential property insurance" means insurance against direct loss to property from the risk of windstorm and hail in the manner as defined and limited in the standard real property and contents insurance forms approved by the commissioner. Essential property insurance may include coverage for either the actual cash value or replacement cost value of the structure and contents. Essential property insurance includes builders risks coverage. The extent of risk covered, the insuring language and the exclusions are all subject to approval by the commissioner. Policies, rules and rates shall be filed with the commissioner in the manner provided for insurance companies.

(b) "Association" means the Mississippi Windstorm Underwriting Association established pursuant to the provisions of this chapter.

(c) "Plan of operation" means the plan of operation of the association approved or promulgated by the commissioner pursuant to the provisions of this chapter.

(d) "Insurable property" means real property, and contents therein when requested, at fixed locations in the coast area, which property is determined by the association to be in an insurable condition and otherwise meets the underwriting requirements of the association. Any one- or two-family dwelling built, rebuilt, altered or remodeled in compliance with the applicable building codes, including design-wind requirements, that is not otherwise rendered uninsurable by reason of use, occupancy or state of repair, shall be an insurable risk. Neighborhood area, location and environmental hazards beyond the control of the applicant or owner of the property shall not be considered in determining insurable condition. "Insurable property" shall not include insurance on motor vehicles or creditor placed insurance on mobile homes. "Insurable property" includes mobile homes, modular homes or manufactured housing that are installed in compliance with applicable codes.

(e) "Commissioner" means the Insurance Commissioner of the State of Mississippi.

(f) "Coast area" means Hancock, Harrison, Jackson, Pearl River, Stone and George Counties.

(g)(i) "Net direct premiums," for purposes of calculating percentages of participation for assessable insurers for the year 2007, means gross direct premiums, excluding reinsurance assumed and ceded, written on property in this state for the risk of windstorm and hail less return premiums upon cancelled contracts, dividends paid or credited to policyholders, or the unused or unabsorbed portion of premium deposits. "Net direct premiums" includes the premium charge component for the risk of windstorm and hail to property in all policies, including multiperil and other policies that package or combine coverage for other risks. The plan of operation shall prescribe the portion of premium allocated for the risk of windstorm and

hail in multiperil and other policies that package or combine coverage for other risks. "Net direct premiums" shall not include farm property. "Net direct premiums" shall not include the property components of motor vehicles and other mobile property, but includes premiums for the risks of windstorm and hail for mobile homes, modular homes or manufactured housing.

(ii) "Net direct premiums," for purposes of calculating percentages of participation for assessable insurers after the year 2007, means those premiums reported by the assessable insurers in their annual statements to the Department of Insurance that were charged for insurance for any and all risks on real property and contents in the state. The department shall determine which lines of real property and contents insurance shall be included in the calculation of net direct premiums. The included real property and contents insurance lines may be changed from time to time in the discretion of the commissioner. "Net direct premiums" shall not include premiums for insuring farm property that are reported timely to the association as provided in the plan of operation.

(iii) The commissioner is authorized and directed to provide to the association annual statements, other reports and any statistics necessary to provide the information herein required and which the commissioner is hereby authorized and empowered to obtain from any assessable insurer.

(h) "Farm property" means property used for farming purposes; however, it shall not include any property used for dwelling purposes or any outbuildings used in connection therewith.

(i) "Losses" includes expenses for the adjustment and resolution of claims and operational and other general expenses.

(j) "Bonds, loans, lines of credit and indebtedness" include interest, finance charges, and any and all other costs associated with the financing.

(k) "Percentage of participation" for an assessable insurer means the percentage determined by dividing the assessable insurers net direct premiums written in this state in the previous year by the aggregate net direct premiums written in this state by all assessable insurers of the association in the previous year. The percentage of participation may be modified as provided in Sections 83-34-9(3) and 83-34-13(2).

(*l*) "Nonadmitted insurers" means those insurance companies defined in Section 83-21-17, and any other companies and persons selling insurance on risks in Mississippi that are not licensed to do business in the State of Mississippi.

(m) "Agents placing insurance through nonadmitted insurers" means those agents defined in Section 83-21-19 and any other agents placing insurance through a nonadmitted insurer.

(n) "Assessable insurer" means each and every insurer authorized to write, and engaged in writing, property insurance within this state on a direct basis.

(o) "Minimum reserve" means an amount set forth in the plan of operation which is maintained by the association for the payment of salaries

and other expenses necessary for the continuous and ongoing operation of the association.

(p) "Recoupable assessment" means any assessment, in whole or in part, that is levied on and payable by assessable insurers to the association which is directly recoverable from policyholders for any covered event. Any assessment levied due to a covered event occurring during the calendar year 2019 shall be a recoupable assessment.

(q) "Nonrecoupable assessment" means any assessment levied on and payable by assessable insurers to the association which is not directly recoverable from policyholders.

(r) "Excess deficit" means a deficit that exceeds available surplus, reinsurance, recoupable and nonrecoupable assessments and other reasonably available assets of the association. The minimum reserve, as set forth in the plan of operation, shall not be considered reasonably available assets of the association when determining whether an excess deficit has occurred.

(s) "Covered event" means an event, such as a hurricane, other windstorm or hailstorm, which causes losses covered by the policies issued by the association to its policyholders.

HISTORY: Laws, 1987, ch. 459, § 2; Laws, 2007, ch. 425, § 5, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 1, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment rewrote the second sentence of (a), which read: "Essential property insurance shall not include coverage for any loss other than the actual cash value of the structure and contents"; added (o) through (s); and made a minor grammatical change.

§ 83-34-3. Creation of Mississippi Windstorm Underwriting Association; organizational structure; certain licensed insurers to become assessable insurers; association revenues; association not subject to state bid requirements.

(1) From and after March 22, 2007, the Mississippi Windstorm Underwriting Association, as created by Chapter 459, Laws of 1987, shall be a separate and independent entity as provided for herein. At its option, the association may incorporate. All assets belonging to the association on or before March 22, 2007, shall hereinafter belong to and remain with the association. There shall be no distribution of income or assets other than for the benefit of the association, which shall have the right to invest and reinvest assets.

(2) From and after March 22, 2007, the association shall no longer have members. Former "members" of the association shall be "assessable insurers" and shall have no rights to the assets and profits of the association, but shall have the obligation for regular assessments as provided herein. Former members shall continue to have the obligations provided in this chapter before March 22, 2007, for all policyholder claims, costs, damages of any kind and

expenses in any manner resulting from losses that occurred before March 22, 2007, for which the association may assess as needed the former members in the manner provided in this chapter before March 22, 2007. As a condition of its authority to continue to transact the business of insurance in this state and by transacting business in this state, each licensed insurer agrees to be bound by the provisions of this statute and the plan of operation as approved by the commissioner, and all amendments and revisions thereto.

(3) Any licensed insurer first authorized to write insurance after March 22, 2007, shall become an assessable insurer on the first day of January immediately following such authorization. The determination of such insurer's participation in the association shall be made based upon writings in the prior year in the same manner as for all other assessable insurers of the association.

(4) Except as provided for in Section 83-34-4(6), the premiums, recoupable and nonrecoupable assessments, fees, investment income and other revenue of the association are funds received for the sole purpose of providing insurance coverage, paying claims for Mississippi citizens insured by the association, securing and repaying debt obligations issued by the association, and conducting all other activities of the association, all as required or permitted by this chapter. Such revenue shall not be considered taxes, fees, licenses or charges for services imposed by the State of Mississippi on individuals, businesses, or agencies, and shall not be used for other purposes.

(5) It is the intent of the Legislature that the association be and act as a nonprofit entity. The association shall be free from taxation of every kind by the state and any political subdivision or other instrumentality thereof. It is the intent of the Legislature that the association be tax exempt from all taxes, including federal taxes, and the association is granted the authority to take those steps necessary to obtain federal tax exempt status.

(6) Any debt obligations issued by the association, their transfer, and the income therefrom, including any profit made on the sale thereof, shall at all times be free from taxation of every kind by the state and any political subdivision or other instrumentality thereof.

(7) In the event of the termination of the association by act of the Legislature, or other means, the assets of the association shall be applied first to pay all debts, liabilities and obligations of the association, including the establishment of reasonable reserves for any contingent liabilities or obligations, and all remaining assets of the association shall become property of the state.

(8) The association shall operate as a private enterprise and shall not be subject to the procurement provisions of Section 31-7-13, and policies and decisions of the association, including, but not limited to, decisions relating to incurring debt, levying of recoupable and nonrecoupable assessments, the issuance and sale of bonds, claims decisions under association policies, hiring and firing of employees, and all services relating to the operation of the association shall not be subject to the provisions of Section 25-9-101 et seq. The association shall not be required to obtain or to hold a license or certificate of authority issued by the commissioner or any other office. The association shall not be required to participate as a member insurer of the Mississippi Insurance Guaranty Association.

HISTORY: Laws, 1987, ch. 459, § 3; Laws, 2007, ch. 425, § 6; Laws, 2014, ch. 426, § 2, eff from and after July 1, 2014; Laws, 2019, ch. 450, § 2, eff from and after July 1, 2019.

Amendment Notes — The 2014 amendment substituted "Except as provided for in Section 83-34-4(6)," for "The" at the beginning of (4).

The 2019 amendment inserted "recoupable and nonrecoupable" in the first sentence of (4) and the first sentence of (8).

§ 83-34-4. Nonadmitted policy fee; responsibility of surplus lines insurance producer placing insurance through nonadmitted insurer to collect and remit fees; calculation of fee; penalty for nonpayment [Repealed effective July 1, 2022].

(1) Nonadmitted insurers shall not be assessable insurers of the association. All surplus lines insurance producers placing insurance through nonadmitted insurers shall collect from the insured and remit to the association a nonadmitted policy fee on all premiums for all insurance written by such surplus lines insurance producer for a policy from a nonadmitted insurer for any and all risks in this state, except that policies or portions thereof that cover residential earthquake risks or residential flood risks that are not written through the National Flood Insurance Program shall be exempt from the nonadmitted policy fee. By procuring or selling insurance on property in this state from a nonadmitted insurer, each surplus lines insurance producer placing insurance through a nonadmitted insurer agrees to be bound by the provisions of this chapter and to collect and remit the nonadmitted policy fee provided for herein.

(2) The nonadmitted policy fee shall be a percentage of the total policy premium but the nonadmitted policy fee shall not be considered premium and is not subject to premium taxes or commissions. However, failure to pay the nonadmitted policy fee shall be treated the same as failure to pay premium. "Total policy premium" includes taxes and commissions.

(3) The nonadmitted policy fee percentage shall be three percent (3%).

(4) Within twenty (20) days of the end of the quarter, surplus lines insurance producers placing insurance through nonadmitted insurers shall remit directly to the association all nonadmitted policy fees collected in the preceding quarter. In addition to the nonadmitted policy fee provided for herein, surplus lines insurance producers placing insurance through nonadmitted insurers shall collect and remit excess deficit surcharges as provided by this chapter. Surplus lines insurance producers placing insurance through nonadmitted insurers may designate another surplus lines insurance producer that actually procured the insurance from the nonadmitted carrier to collect and remit the nonadmitted policy fees.

(5) Each insured in this state who directly procures or renews insurance with a nonadmitted insurer on properties, risks or exposures located or to be performed, in whole or in part, in this state, other than insurance procured through a surplus lines licensee, shall be subject to the nonadmitted policy fee

which shall be paid by the insured according to the procedures provided for premium taxes in Section 83-21-17(5).

(6) Monies derived from the nonadmitted policy fee collected under this section may be used by the association, in addition to any uses provided for in Section 83-34-3(4), for education, public outreach, training of building officials and other programs targeted to reduce the number of policies within the association; however, beginning on July 1, 2018, and ending on June 30, 2019, before any fees are remitted to the association, One Million Five Hundred Thousand Dollars ($1,500,000.00) shall be diverted and deposited into the Capital Expense Fund, and Four Million Five Hundred Thousand Dollars ($4,500,000.00) shall be diverted and deposited into the Rural Fire Truck Fund or Supplementary Rural Fire Truck Fund. Further, beginning July 1, 2019, and ending on June 30, 2020, before any fees are remitted to the association, Three Million Five Hundred Thousand Dollars ($3,500,000.00) shall be diverted and deposited into the Rural Fire Truck Fund or Supplementary Rural Fire Truck Fund.

(7) This section shall stand repealed from and after July 1, 2022.

HISTORY: Laws, 2007, ch. 425, § 7; Laws, 2011, ch. 380, § 9; Laws, 2012, ch. 375, § 1; Laws, 2014, ch. 426, § 1 eff from and after July 1, 2014; Laws, 2018, ch. 459, , eff from and after July 1, 2018; Laws, 2019, ch. 450, § 3, eff from and after July 1, 2019.

Amendment Notes — The 2012 amendment deleted "collected after January 1, 2008" following "all premiums" in the second sentence of (1); substituted "three percent (3%)" for "five percent (5%)" at the end of (3); and added (6).

The 2014 amendment, in (1), added "except that policies . . . . policy fee" to the second sentence; added (6); redesignated former (6) as (7), and therein substituted "July 1, 2018" for "July 1, 2014."

The 2018 amendment added "however, beginning on July 1, 2018...shall be diverted and deposited into the Rural Fire Truck Fund or Supplementary Rural Fire Truck Fund" at the end of (6); and extended the date of the repealer for the section by substituting "July 1, 2019" for "July 1, 2018" in (7).

The 2019 amendment inserted "excess deficit" in the second sentence of (4); added the last sentence of (6); and extended the date of the repealer for the section by substituting "July 1, 2022" for "July 1, 2019" in (7).

Cross References — Rural Fire Truck Fund, see § 17-23-1.

Supplementary Rural Fire Truck Fund, see § 17-23-11.

§ 83-34-5. Powers and duties.

The association shall, pursuant to the provisions of this chapter and the plan of operation, and with respect to essential property insurance on insurable property, have the power:

(a) To issue policies of essential property insurance on insurable property to applicants;

(b) At its option, and with consent of the commissioner, to issue policies of related essential property insurance on insurable property to applicants;

(c) To purchase reinsurance for all or part of the risks of the association;

(d) To levy and collect recoupable and nonrecoupable assessments from assessable insurers;

(e) To issue bonds or incur other forms of indebtedness, including, but not limited to, loans, lines of credit or letters of credit;

(f) To establish underwriting criteria consistent with the provisions of this chapter and as approved by the commissioner;

(g) To invest and reinvest income and assets subject to the oversight of the commissioner;

(h) To enter into contractual agreements with third parties, including the Mississippi Windstorm Mitigation Coordinating Council, for the purposes of developing and implementing windstorm mitigation programs; and

(i) All other powers necessary to carry out the provisions and intent of this chapter.

HISTORY: Laws, 1987, ch. 459, § 4; Laws, 2007, ch. 425, § 8; Laws, 2011, ch. 460, § 2, eff from and after July 1, 2011; Laws, 2019, ch. 450, § 4, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment inserted "recoupable and nonrecoupable" in (d).

§ 83-34-9. Participation by assessable insurers in recoupable and nonrecoupable assessments levied by association; financial incentives and/or penalties to ensure assessable insurers write insurance in the coast area.

(1) All assessable insurers of the association shall participate in recoupable and nonrecoupable assessments levied by the association based upon their percentage of participation. The association may allow affiliated insurers to combine their annual net direct premiums and other data, including data that supports any incentives that may be allowed by the association, to the extent that such grouping promotes the voluntary writing of essential property insurance in the coast area. Any provisions for credits and grouping of data shall be prescribed in the plan of operation.

(2) All profits of the association shall remain as assets of the association.

(3) The plan of operation shall provide financial incentives or financial penalties, or both, to ensure that assessable insurers write essential property insurance in the coast area. The incentives and penalties may include, but are not limited to, a reduction in recoupable and nonrecoupable assessments, adjustments in the percentage of participation, and other incentives and penalties as provided in the plan of operation. The commissioner shall approve the plan of operation as provided in Section 83-34-13.

HISTORY: Laws, 1987, ch. 459, § 6; Laws, 2007, ch. 425, § 10, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 5, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment inserted "recoupable and nonrecoupable" in the first sentence of (1); and in the second sentence of (3), substituted "recoupable and nonrecoupable assessments" for "recovery of regular assessments," and

deleted "a nonrecoverable participation in losses incurred by the association above the amounts covered by the regular assessments" thereafter.

JUDICIAL DECISIONS

1. Association's negligent misrepresentation.

Underwriting association erred in denying an insurer's request to submit corrected data from which the insurer's participation in the association's insurance pool was calculated, after a deadline, because the association's negligent misrepresentation to the insurer caused the untimely submission, tolling the deadline as applied to the insurer, as (1) the association did not correct a mistaken response, (2) the misrepresentation that the insurer could not receive credits for excess policies was material, (3) the association's decision to provide wrong information showed a lack of diligence the public was entitled to expect, (4) the insurer reasonably relied on the representation and was damaged by not receiving credits the insurer was statutorily entitled to, and (5) the deadline was not immutable or not subject to other mitigating principles of law. Arrowood Indem. Co. v. Miss. Windstorm Underwriting Ass'n, 201 So. 3d 453, 2016 Miss. LEXIS 249 (Miss. 2016).

§ 83-34-10. Power to levy recoupable and nonrecoupable assessments upon occurrence of certain events; maximum nonrecoupable assessments.

(1) In the event of a covered event that may produce losses in excess of funds that may be immediately available to the association, or in the event that the association determines that it will otherwise have a claim deficit or any other deficit, then the association, with consent of the commissioner, shall have the power to levy recoupable and nonrecoupable assessments against assessable insurers based upon their percentage of participation.

The minimum reserve, as set forth in the plan of operation, shall not be considered as funds available to the association in determining whether to levy a recoupable or nonrecoupable assessment.

(2) A nonrecoupable assessment levied under this section shall not exceed six percent (6%) of the association's year-end total limits in force for the preceding calendar year, or Two Hundred Fifty Million Dollars ($250,000,000.00), whichever is less. Further, in any calendar year, the annual total of all nonrecoupable assessment funds collected shall not exceed, in the aggregate, Two Hundred Fifty Million Dollars ($250,000,000.00).

HISTORY: Laws, 2007, ch. 425, § 11, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 6, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment, in (1), in the first sentence, substituted "covered event" for "storm" and substituted "recoupable and nonrecoupable assessments" for "regular assessments," deleted the former last two sentences, which read: "In any year, the annual total of regular assessments shall not exceed the greater of ten percent (10%) of the deficit or ten percent (10%) of the aggregate statewide direct written premiums for property insurance for the prior calendar year of all association assessable insurers. Regular assessments shall be paid by assessable insurers within sixty (60) days of receipt of the notice of the assessments," and added the second paragraph; and added (2).

§ 83-34-11. Repealed.

Repealed by Laws, 2019, ch. 450, § 13, eff from and after July 1, 2019.

§ 83-34-11. [Laws, 1987, ch. 459, § 7; Laws, 2007, ch. 425, § 12, eff from and after passage (approved Mar. 22, 2007).]

Editor's Notes — Former § 83-34-11 implemented a surcharge on all property and casualty insurance premiums in Mississippi.

§ 83-34-12. Deferment of assessable insurer's recoupable or nonrecoupable assessment; amount deferred to be assessed against other assessable insurers.

The recoupable or nonrecoupable assessment of an assessable insurer may, after hearing, be ordered deferred, in whole or in part, upon application by the insurer if, in the opinion of the commissioner, payment of the recoupable or nonrecoupable assessment would render the insurer insolvent or in danger of insolvency, or would otherwise leave the insurer in such a condition that further transaction of the insurer's business would be hazardous to its policyholders, creditors, assessable insurers, subscribers, stockholders or the public. If that payment of a recoupable or nonrecoupable assessment against an assessable insurer is deferred by order of the commissioner, in whole or in part, the amount by which the recoupable or nonrecoupable assessment is deferred shall be assessed against other assessable insurers in the same manner as provided in Section 83-34-9.

HISTORY: Laws, 2007, ch. 425, § 13, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 7, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment substituted "recoupable or nonrecoupable assessment" for "regular assessment" near the beginning, inserted "recoupable or nonrecoupable" the next three times it appears, and made a minor related change.

§ 83-34-13. Plan of operation; contents; approval by commissioner; certification of approval; effective date of plan.

(1) Within forty-five (45) days after March 22, 2007, the directors of the association shall submit to the commissioner for review and approval a proposed plan of operation revised to be consistent with the provisions of Chapter 425, Laws of 2007. The association shall maintain a plan of operation. The plan shall provide for the efficient, economical, fair and nondiscriminatory administration of the association. The plan may include the establishment of a minimum reserve, methods for the nonrecoupable assessment of all assessable insurers for deficits and expenses, the establishment of necessary facilities, management of the association, underwriting standards, procedures for determining the amounts of insurance to be provided to specific risks, time limits and procedures for processing applications for insurance, and for such other provisions as may be deemed necessary by the board to carry out the

purposes of this chapter. The plan of operation shall include in the plan of operation a mechanism for recoupment of recoupable assessments.

(2) The plan of operation shall provide financial incentives or financial penalties, or both, to ensure that assessable insurers write essential property insurance in the coast area. The incentives and penalties may include, but are not limited to, a reduction in nonrecoupable assessments, adjustments in the percentage of participation, and other incentives and penalties as provided in the plan of operation.

(3) The plan of operation shall provide (a) that the association shall offer a two percent (2%) deductible for loss from named storms; and (b) that the association shall also offer options for other deductibles for loss from named storms with appropriate rate reductions that shall include at least a twenty percent (20%) deductible for loss from named storms.

(4) The plan of operation shall provide that the association use actuarially appropriate geographical zones for rating and for the use of credits and penalties to encourage voluntary writing in the coast area.

(5) The commissioner shall approve the plan of operation and all amendments before they become effective. It is the obligation of the commissioner to confirm that such plan fulfills the purposes of this chapter. If the commissioner approves a proposed plan or amendment, he shall certify the approval to the directors, and the plan, or amendment thereto, shall become effective ten (10) days after such certification. If the commissioner disapproves all or any part of the proposed plan of operation, or amendment thereto, he shall return the same to the directors with a written statement giving the reasons for disapproval and any recommendations the commissioner may wish to make. Within ten (10) days thereafter, the directors may alter the plan or amendment in accordance with the commissioner's recommendation or may return a new plan to the commissioner. The commissioner shall consider the proposals and shall then promulgate and place into effect a plan of operation certifying the same to the directors of the association after approval by the board of directors. Any such plan promulgated by the commissioner shall take effect ten (10) days after certification to the directors.

(6) The commissioner may review the plan of operation at any time he deems expedient or prudent. After review of the plan, the commissioner may amend the plan after consultation with the directors of the association and upon certification to the directors of the amendment.

HISTORY: Laws, 1987, ch. 459, § 8; Laws, 2007, ch. 425, § 14, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 8, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment, in (1), inserted "the establishment of a minimum reserve" and "nonrecoupable" in the fourth sentence, and added the last sentence; and in the second sentence of (2), substituted "nonrecoupable assessments" for "recovery of regular assessments" and deleted "a nonrecoverable participation in losses incurred by the association above the amounts covered by the regular assessments" thereafter.

§ 83-34-23. Immunity from liability.

There shall be no liability on the part of the insurance commissioner or any of his staff and representatives for any action taken under and pursuant to the provisions of this chapter. There shall be no liability on the part of the association, its agents, representatives or employees, the members of the board, or any assessable insurer of the association, except for the specific obligations stated in any contract of insurance and the duty to pay assessments as provided in this chapter.

HISTORY: Laws, 1987, ch. 459, § 13; Laws, 2007, ch. 425, § 19, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 9, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment substituted "except for the specific obligations stated in any contract" for "except for the contractual obligations of any contract" near the end.

§ 83-34-31. Powers and authority of board of directors to issue bonds and enter into loans or other forms of indebtedness; rights and remedies of bondholders not to be impaired.

(1) The board of directors, subject to the approval of the commissioner, shall have the power and authority to issue bonds, and the power and authority to enter into loans, letters of credit, lines of credit, and other forms of indebtedness, as needed for operations, the purchase of reinsurance, claim losses, and incurred but not reported claims.

(2) The bonds must be in a form approved by the commissioner. With approval of the commissioner, the association may issue bonds or incur other indebtedness to retire or consolidate bonds as appropriate. Bonds and other debt obligations issued by or on behalf of the association are not to be considered "state bonds" and shall not be an obligation of the state.

(3) The state hereby covenants with holders of bonds issued pursuant to this chapter that the state will not limit, alter or deny the duties and obligations of this chapter, and of the association and the commissioner as established by this chapter, necessary to fulfill the terms of any agreements with bondholders, or in any way impair the rights and remedies of such bondholders as long as any such bonds remain outstanding unless adequate provision has been made for the payment of such bonds pursuant to the documents authorizing the issuance of such bonds.

HISTORY: Laws, 2007, ch. 425, § 21, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 10, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment deleted former (2), which read: "All such bonds and loans are secured by the power and duty of the commissioner to implement surcharges against all property and casualty insurance premiums for insurance for property and activities in this state sufficient to repay the bonds or loans,

or both"; redesignated former (3) and (4) as (2) and (3); deleted the former first two sentences of present (2), which read: "If any of the bonds remain unsold sixty (60) days after issuance, the commissioner shall require all assessable insurers to purchase the bonds, which purchased bonds shall be treated as admitted assets; each assessable insurer shall be required to purchase that percentage of the unsold portion of the bond issue that equals the assessable insurer's current percentage of participation. An assessable insurer shall not be required to purchase the bonds to the extent that the commissioner determines that the purchase would endanger or impair the solvency of the insurer"; and substituted "pursuant to this chapter" for "pursuant to this section" in present (3).

§ 83-34-33. Surcharge for excess covered event losses on all property and casualty premiums; issuance of bonds to pay claims losses; exempted premiums; purpose of certain surcharges to be designated and specifically identified; licensed insurers and agents to collect and remit surcharges; setting and adjustment of surcharge percentage; cessation of surcharge.

(1) When the association knows or has reason to believe that (a) it has or will incur losses from a covered event that exceeds available surplus, reinsurance, recoupable or nonrecoupable assessments and other reasonably available assets of the association, such that one or more bond issues or other financing, or both, will be necessary to pay claims losses and other related expenses, or (b) the association has an excess deficit that cannot be reasonably resolved by income available to the association above the minimum reserve, then the association shall immediately give notice to the commissioner and request that the commissioner implement an excess deficit surcharge on all property and casualty insurance premiums for insurance for property and operations in this state designed to recover to the association the amount of all such bonds and other indebtedness resulting from the covered event, or other deficit.

(2) All such bonds and loans are secured by the power and duty of the commissioner to implement surcharges against all property and casualty insurance premiums for insurance for property and activities in this state sufficient to repay the bonds or loans, or both.

(3) If any of the bonds remain unsold sixty (60) days after issuance, the commissioner shall require all assessable insurers to purchase the bonds, which purchased bonds shall be treated as admitted assets; each assessable insurer shall be required to purchase that percentage of the unsold portion of the bond issue that equals the assessable insurer's current percentage of participation. An assessable insurer shall not be required to purchase the bonds to the extent that the commissioner determines that the purchase would endanger or impair the solvency of the insurer. The bonds must be in a form approved by the commissioner. With approval of the commissioner, the association may issue bonds or incur other indebtedness to retire or consolidate bonds as appropriate. Bonds and other debt obligations issued by or on behalf of the association are not to be considered "state bonds" and shall not be an obligation of the state.

(4) At such time as the commissioner can reasonably estimate the amount of bonds or indebtedness, or both, necessitated by a covered event, and in no event more than ninety (90) days from the notice given by the association, the commissioner shall have the duty and the power to implement an excess deficit surcharge on all property and casualty insurance premiums for insurance for property and activities in this state. "Premiums" includes premiums for policies issued by or for the association and by or for the Mississippi Residential Property Insurance Underwriting Association. "Premiums" shall not include premiums for workers' compensation coverage, premiums for medical malpractice liability coverage including medical malpractice liability coverage issued by companies created under Section 83-47-1 et seq., nor any premiums for coverage by insurance pools or plans administered by or through the State of Mississippi.

(5) If the excess deficit surcharge is designed to repay bonds, it shall be designated as such and all funds recovered from the excess deficit surcharge shall be used for repayment of the bonds for which it was implemented, until such time as the bonds have been paid or redeemed.

(6) If the excess deficit surcharge is designed to repay a specific indebtedness incurred for losses from a specific covered event, it shall be designated as such and all funds recovered from the excess deficit surcharge shall be used for repayment of the indebtedness for which it was implemented, until such time as the indebtedness has been paid or redeemed.

(7) Such excess deficit surcharge shall be specifically identified on either the premium statements or the policy declarations pages or other appropriate policy forms as relating to the specific covered event losses or bonds or indebtedness for which it was implemented. The commissioner shall name each such excess deficit surcharge so that it can be uniformly identified by insurers and agents.

(8) The excess deficit surcharge shall be a percentage of the total policy premium but the excess deficit surcharge shall not be considered premium and is not subject to premium taxes or commissions. However, failure to pay the excess deficit surcharge shall be treated the same as failure to pay premium. "Total policy premium" includes taxes and commissions.

(9) The commissioner shall implement an appropriate excess deficit surcharge percentage sufficient to recover the amount necessary for repayment of bonds and indebtedness necessitated by a covered event, or the resolution of other deficit, as applicable. If at any time such surcharge shall be insufficient, the commissioner shall increase the excess deficit surcharge as necessary and appropriate. The commissioner shall cease excess deficit surcharges as he determines appropriate funds have been collected. However, the commissioner shall endeavor to apply excess deficit surcharges on a one-year basis in order to promote consistency, nondiscrimination and fairness among policyholders purchasing or renewing insurance during that year. Any collections in excess of the amounts needed shall be assets of the association for investment and other uses.

(10) Each licensed insurer issuing insurance for property and casualty risks in the state and each agent placing insurance through nonadmitted

insurers, shall collect the excess deficit surcharges established by the commissioner under the authority of this section. Funds collected by such licensed insurers and agents placing insurance through nonadmitted insurers as excess deficit surcharges authorized by this section shall be collected and held in trust and shall be fully remitted to the association on a quarterly basis with forms providing appropriate information as designed by the association. Insurers and agents shall remit such funds to the association within twenty (20) days after the end of each quarter. At such time the insurers and agents shall further remit to the association all interest earned on the excess deficit surcharge funds.

(11) The association and the commissioner are both specifically given the power to audit licensed insurers and agents placing insurance through nonadmitted insurers to confirm the accuracy of remittances of excess deficit surcharges at the expense of the licensed insurers and agents.

(12) The commissioner has the duty and power to adjust the percentage of any excess deficit surcharge previously established as he finds appropriate taking into consideration any relevant factors, including, but not limited to, consolidation or replacement of bonds, any additional indebtedness resulting from a covered event, the rate of recovery, anticipated length of total recovery, and impact of other covered events; however, the commissioner shall not reduce the amount of excess deficit surcharges implemented and designated to pay or redeem bonds, or other indebtedness below the amount necessary to timely pay or redeem such bonds, or other indebtedness.

(13) When the association knows or has reason to believe that excess deficit surcharges authorized by this section previously established by the commissioner will be insufficient to timely pay or redeem bonds or indebtedness, the association shall immediately give notice to the commissioner. The commissioner shall alter such excess deficit surcharge as necessary to timely pay or redeem bonds or pay other indebtedness.

(14) The association shall report quarterly to the commissioner providing all financial information for each excess deficit surcharge authorized by this section, including:

(a) The original and current outstanding indebtedness of all bonds and loans;

(b) Total excess deficit surcharge funds recovered to date; and

(c) Any information requested by the commissioner.

(15) The commissioner may request, and the association shall provide, on an immediate basis to the commissioner any financial information or other information concerning any excess deficit surcharge. This section shall not limit the reporting requirements provided by Section 83-34-25.

HISTORY: Laws, 2007, ch. 425, § 22, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 11, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment, in (1), substituted "losses from a covered event that exceeds available surplus, reinsurance, recoupable or nonrecoupable assessments and other" for "losses from a hurricane that exceeds reinsurance and

other," inserted "an excess" and "above the minimum reserve," substituted "implement an excess deficit surcharge" for "implement by an excess hurricane loss surcharge"; added (2) and (3); redesignated former (2) through (13) as (4) through (15); inserted "excess deficit" everywhere it appears in (5) through (15); and substituted "covered event" and "covered events" for "hurricane event" and "hurricane events" everywhere they appear in (5) through (15).

§ 83-34-35. Commissioner to approve association rates at least adequate to fund annual reinsurance above a certain reserve.

In order to avoid or lessen the possibility and amount of excess deficit surcharges authorized by this chapter, the commissioner shall approve rates for policies issued by the association at least adequate to fund annual reinsurance above a self-insured retention of One Hundred Million Dollars ($100,000,000.00) that, combined with any readily available reserves of the association, is sufficient to cover at least the probable maximum losses from a storm expected to occur once every one hundred (100) years as predicted by a model or method approved by the commissioner for the properties insured by the association at the time the reinsurance was negotiated. The amount of reinsurance in the foregoing rate adequacy requirement shall increase every two (2) years by increasing the probable maximum loss by five (5) years, until such time as the probable maximum loss insured is for a storm expected to occur every one hundred fifty (150) years. The commissioner may approve rates in excess of the minimums required by this section as consistent with his duties and the insurance laws of the State of Mississippi. Any self-insured retention related to the purchase of reinsurance shall be subject to the prior approval of the commissioner.

HISTORY: Laws, 2007, ch. 425, § 23, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 12, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment inserted "excess deficit" near the beginning; and added the last sentence.

CHAPTER 37.

BURIAL ASSOCIATIONS

Sec.

83-37-29. Penalties; funding of agency expenses; deposit of monies into State General Fund.

§ 83-37-29. Penalties; funding of agency expenses; deposit of monies into State General Fund.

Any person, firm, association, or corporation engaging in the business herein described without first having complied with the provisions hereof, or any person who shall knowingly make any false statement in the reports required by this chapter as determined by the Commissioner of Insurance after

written notice and hearing, shall be assessed a penalty for each violation of not less than Two Hundred Fifty Dollars ($250.00) nor more than Five Hundred Dollars ($500.00), and in addition thereto shall forfeit the license to do business in this state. Funds from such penalties shall be deposited with the State Treasurer to be placed in a fund designated as the "Insurance Department Fund."

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1930, § 4001; 1942, § 5603; Laws, 1928, ch. 197; Laws, 1991, ch. 450 § 1; Laws, 2016, ch. 459, § 33, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Amendment Notes — The 2016 amendment added the last two paragraphs.

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

CHAPTER 39.

BAIL BONDS AND BONDSMEN

Sec.

83-39-3. Individual license required; funding of agency expenses; deposit of monies into State General Fund.

83-39-7. Qualification bond; return of defendant out on bond; return of qualification bond.

83-39-8. Managing and closing business upon death of personal surety.

83-39-13. Annual financial statement; maintenance and registration of office physically located in Mississippi municipality or county required; Bail Bond Database.

83-39-15. Grounds for denial, suspension, revocation, and refusal to renew license.

83-39-23. Notice to sheriff and judicial officials.

83-39-27. Prohibited activities.

83-39-29. Penalties.

83-39-30. Prohibited activities; illegal business referrals.

§ 83-39-1. Definitions.

JUDICIAL DECISIONS

4. Service of process.

Service of process on a bail bondsman's agent was insufficient when defendant failed to appear at trial because by statute

an agent could not be served to achieve service of process on a bail bondsman. However, because the bail bondsman remained as surety for defendant, reversal and remand were appropriate for proper process of scire facias to be had on the bail bondsman, at which point the trial court could proceed in accordance with the applicable law. Newell v. State, 282 So. 3d 655, 2019 Miss. App. LEXIS 335 (Miss. Ct. App. 2019).

§ 83-39-3. Individual license required; funding of agency expenses; deposit of monies into State General Fund

(1) No person shall act in the capacity of professional bail agent, soliciting bail agent or bail enforcement agent, as defined in Section 83-39-1, or perform any of the functions, duties or powers of the same unless that person shall be qualified and licensed as provided in this chapter. The terms of this chapter shall not apply to any automobile club or association, financial institution, insurance company or other organization or association or their employees who execute bail bonds on violations arising out of the use of a motor vehicle by their members, policyholders or borrowers when bail bond is not the principal benefit of membership, the policy of insurance or of a loan to such member, policyholder or borrower.

(2)(a) No license shall be issued or renewed except in compliance with this chapter, and none shall be issued except to an individual. No firm, partnership, association or corporation, as such, shall be so licensed. No professional bail agent shall operate under more than one (1) trade name. A soliciting bail agent and bail enforcement agent shall operate only under the professional bail agent's name. No license shall be issued to or renewed for any person who has ever been convicted of a crime that the commissioner finds directly relates to the duties and responsibilities of the business of a professional bail agent, soliciting bail agent, or bail enforcement agent, including, but not limited to, any felony that involves an act of fraud, dishonesty, or a breach of trust, or money laundering. No license shall be issued to any person who is under twenty-one (21) years of age. No person engaged as a law enforcement or judicial official or attorney shall be licensed hereunder. A person who is employed in any capacity at any jail or corrections facility that houses state, county or municipal inmates who are or may be eligible for bail, whether the person is a public employee, independent contractor, or the employee of an independent contractor, may not be licensed under this section.

(b)(i) No person who is a relative of either a sworn state, county or municipal law enforcement official or judicial official, or an employee, independent contractor or the contractor's employee of any police department, sheriff's department, jail or corrections facility that houses or holds federal, state, county or municipal inmates who are or may be eligible for bail, shall write a bond in the county where the law enforcement entity or court in which the person's relative serves is located. "Relative" means a

spouse, parent, grandparent, child, sister, brother, or a consanguineous aunt, uncle, niece or nephew. Violation of this prohibition shall result in license revocation.

(ii) No person licensed under this chapter shall act as a personal surety agent in the writing of bail during a period he or she is licensed as a limited surety agent, as defined herein.

(iii) No person licensed under this chapter shall give legal advice or a legal opinion in any form.

(3) The department is vested with the authority to enforce this chapter. The department may conduct investigations or request other state, county or local officials to conduct investigations and promulgate such rules and regulations as may be necessary for the enforcement of this chapter. The department may establish monetary fines and collect such fines as necessary for the enforcement of such rules and regulations. All fines collected shall be deposited in the Special Insurance Department Fund for the operation of that agency.

(4)(a) Each license issued hereunder shall expire biennially on the last day of September of each odd-numbered year, unless revoked or suspended prior thereto by the department, or upon notice served upon the commissioner by the insurer that the authority of a limited surety agent to act for or on behalf of such insurer had been terminated, or upon notice served upon the commissioner that the authority of a soliciting bail agent or bail enforcement agent had been terminated by such professional bail agent.

(b) A soliciting bail agent or bail enforcement agent may, upon termination by a professional bail agent or upon his cessation of employment with a professional bail agent, be relicensed without having to comply with the provisions of subsection (7)(a) and (b) of this section, if he has held a license in his respective license category within ninety (90) days of the new application, meets all other requirements set forth in Section 83-39-5 and subsection (7)(b) of this section, and notifies the previous professional bail agent in writing that he is submitting an application for a new license.

(5) The department shall prepare and deliver to each licensee a license showing the name, address and classification of the licensee, and shall certify that the person is a licensed professional bail agent, being designated as a personal surety agent or a limited surety agent, a soliciting bail agent or a bail enforcement agent. In addition, the license of a soliciting bail agent or bail enforcement agent, shall show the name of the professional bail agent and any other information as the commissioner deems proper.

(6) The commissioner, after a hearing under Section 83-39-17, may refuse to issue a privilege license for a soliciting bail agent to change from one (1) professional bail agent to another if he owes any premium or debt to the professional bail agent with whom he is currently licensed. The commissioner, after a hearing under Section 83-39-17, shall refuse to issue a license for a limited surety agent if he owes any premium or debt to an insurer to which he has been appointed. If a license has been granted to a limited surety agent or a soliciting bail agent who owed any premium or debt to an insurer or professional bail agent, the commissioner, after a hearing under Section 83-39-17, shall revoke the license.

(7)(a) Before the issuance of any initial professional bail agent, soliciting bail agent or bail enforcement agent license, the applicant shall submit proof of successful completion of forty (40) hours of prelicensing education approved by the Mississippi Insurance Department unless the applicant is currently licensed under this chapter on July 1, 2014, and has maintained that license in compliance with the continuing education requirements of subsection (8) of this section. Any applicant who has met all continuing education requirements as set forth in subsection (8)(a) of this section and has been properly licensed under this chapter within ninety (90) days of submitting an application for a license shall not be subject to the prelicensing education requirement.

(b) All applicants for a professional bail agent, soliciting bail agent or bail enforcement agent license applying for an original license after July 1, 2014, shall successfully complete a limited examination by the department for the restricted lines of business before the license can be issued; however, this examination requirement shall not apply to any licensed bail soliciting agent and bail enforcement agent transferring to another professional bail agent license, any licensed bail soliciting agent applying for a bail enforcement agent license, and any licensed bail enforcement agent applying for a bail soliciting agent license. An applicant shall only be required to successfully complete the limited examination once.

(c) Beginning on July 1, 2011, in order to assist the department in determining an applicant's suitability for a license under this chapter, the applicant shall submit a set of fingerprints with the submission of an application for license. The department shall forward the fingerprints to the Department of Public Safety for the purpose of conducting a criminal history record check. If no disqualifying record is identified at the state level, the Department of Public Safety shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. Fees related to the criminal history record check shall be paid by the applicant to the commissioner and the monies from such fees shall be deposited in the special fund in the State Treasury designated as the "Insurance Department Fund."

(8)(a) Before the renewal of the license of any professional bail agent, soliciting bail agent or bail enforcement agent, the applicant shall submit proof of successful completion of continuing education hours as follows:

(i) There shall be no continuing education required for the first licensure year;

(ii) Except as provided in subparagraph (i), eight (8) hours of continuing education for each year or part of a year of the two-year license period, for a total of sixteen (16) hours per license period.

(b) If an applicant for renewal failed to obtain the required eight (8) hours for each year of the license period during the actual license year in which the education was required to be obtained, the applicant shall not be eligible for a renewal license but shall be required to obtain an original license and be subject to the education requirements set forth in subsection

(7). The commissioner shall not be required to comply with Section 83-39-17 in denying an application for a renewal license under this paragraph (b).

(c) The education hours required under this subsection (8) shall be approved by the Mississippi Insurance Department.

(d) The continuing education requirements under this subsection (8) shall not be required for renewal of a bail agent license for any applicant who is sixty-five (65) years of age and who has been licensed as a bail agent for a continuous period of twenty (20) years immediately preceding the submission of the application as evidenced by submission of an affidavit, under oath, on a form prescribed by the department, signed by the licensee attesting to satisfaction of the age, licensing, and experience requirements of this paragraph (d).

(9) No license as a professional bail agent shall be issued unless the applicant has been duly licensed by the department as a soliciting bail agent for a period of three (3) consecutive years immediately preceding the submission of the application. However, this subsection (9) shall not apply to any person who was licensed as a professional bail agent before July 1, 2011.

(10) A nonresident person may be licensed as a professional bail agent, bail soliciting agent or bail enforcement agent if:

(a) The person's home state awards licenses to residents of this state on the same basis; and

(b) The person has satisfied all requirements set forth in this chapter.

(11) On or before October 1, 2016, the Insurance Department shall establish a statewide Electronic Bondsmen Registry for all licenses, powers of appointment and powers of attorney requiring registration under this section. Once established, each professional bail agent, limited surety agent, bail soliciting agent, bail enforcement agent or insurance company writing bail bonds shall be required under this subsection (11) to register and maintain a record of each required license, power of appointment and power of attorney in the registry. Failure to comply with this provision will subject the agent to the penalties provided in Section 83-39-29.

(12) From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

(13) From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1942, § 8745-02; Laws, 1968, ch. 341, § 2; Laws, 1994, ch. 495, § 2; Laws, 1997, ch. 410, § 19; Laws, 1999, ch. 497, § 1; Laws, 2001, ch. 353, § 1; Laws, 2001, ch. 563, § 1; Laws, 2006, ch. 586, § 1; Laws, 2007, ch. 501, § 3; Laws, 2008, ch. 467, § 1; Laws, 2010, ch. 466, § 2; Laws, 2011, ch. 463, § 4; Laws, 2012, ch. 394, § 1; Laws, 2013, ch. 423, § 1; Laws, 2014, ch. 479, § 1; Laws, 2016, ch. 446, § 1; Laws, 2016, ch. 459, § 34, eff from and after July 1, 2016; reenacted without change, Laws, 2018, ch. 362, § 1, eff from and after July 1, 2018.

Joint Legislative Committee Note — Laws of 2016, ch. 446, § 4, was amended by Laws of 2018, ch. 362, § 4, to delete the July 1, 2018, repealer for this section.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Laws of 2016, ch. 446, § 4, was amended by Laws of 2018, ch. 362, § 4, to delete the July 1, 2018, repealer for this section.

Amendment Notes — The 2012 amendment rewrote (4); in (7)(a), inserted "initial" preceding "professional bail agent" in the first sentence; and added the last sentence.

The 2013 amendment added the second sentence in (7)(a).

The 2014 amendment substituted "or may be eligible for bail" for "bailable" in the last sentence of (2)(a) and the first sentence of (2)(b)(i); redesignated former (4) as present (4)(a) and (4)(b); in present (4)(a), inserted "of each odd-numbered year" following "on the last day of September" and substituted "on" for "in" following "surety agent to act for or"; in present (4)(b), inserted "and (b)" following "subsection (7)(a)" and deleted the last sentence; in (5), substituted "the licensee" for "such licensee" in the first sentence and "of a" for "if for" in the second sentence; added (7)(b); in (7)(a), deleted the second sentence; inserted "unless the applicant . . . of this section" following the end of the first sentence and "has met all . . . of this section and" following "Any applicant who" in the last sentence; and deleted "different" following "application for a" and "type" preceding "shall not be subject" near the end of the last sentence; in the second sentence of (7)(c), deleted "the fingerprints shall be forwarded by" following "identified at the state level" and inserted "shall forward the fingerprints" following "Department of Public Safety"; in (8)(a)(i), inserted "licensure" following "required for the first" and deleted "of completion of the forty (40) hour pre-license class"; and in (8)(d), deleted "professional" preceding "bail agent" twice.

The first 2016 amendment (ch. 446) rewrote the fifth sentence of (2)(a), which read: "No license shall be issued to or renewed for any person who has ever been convicted of a felony or any crime involving moral turpitude or who is under twenty-one (21) years of age" and divided it into the present fifth and sixth sentences; in (7)(a), substituted "(40) hours of prelicensing education approved by the Mississippi Insurance Department unless" for "(40) classroom hours of prelicensing education approved by the Professional Bail Agents Association of Mississippi, Inc., and conducted by persons or entities approved by the Professional Bail Agents Association of Mississippi, Inc., unless" and deleted the former second sentence, which read: "The hours required by this subsection shall be classroom hours and may not be acquired through correspondence or over the Internet"; in (8), deleted "classroom" preceding "hours" in (a)(ii), and rewrote (c) to delete references to the Professional Bail Agents Association of Mississippi, Inc.; and added (11).

The second 2016 amendment (ch. 459) added (11) and (12), which were renumbered (12) and (13) by the Code Committee.

The 2018 amendment reenacted the section without change.

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

JUDICIAL DECISIONS

1. Constitutionality.

Licensing requirement, Miss. Code Ann. § 83-39-3(2), violated the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution where the State failed to articulate any rationale basis for precluding all felons, regardless of the nature or age of the felony, from holding bail-agent licenses. Chunn v. State ex rel. Miss. Dep't of Ins., 156 So. 3d 884, 2015 Miss. LEXIS 36 (Miss. 2015).

§ 83-39-7. Qualification bond; return of defendant out on bond; return of qualification bond.

(1)(a) Each applicant for a professional bail agent license who acts as personal surety shall be required to post a qualification bond in the amount of Thirty Thousand Dollars ($30,000.00).

(b) The Insurance Department shall submit a report to the Senate and House of Representatives Committees on Accountability, Efficiency and Transparency that details the amount of all bonds or undertakings that each bail bondsman has written in this state on which the bail bondsman is absolutely or conditionally liable since the Bail Bond Database was established by the department. The report shall be submitted on or before December 1, 2017. The report shall also include the number of bail bondsmen who have failed to comply with the database reporting requirements, if any, the technical issues that may have occurred since the database was established and any suggested legislation to ensure each bail bondsman's continued compliance with the database reporting requirements.

(2) The qualification bond shall be made by depositing with the commissioner the aforesaid amount of bonds of the United States, the State of Mississippi or any agency or subdivision thereof, or a certificate of deposit issued by an institution whose deposits are insured by the Federal Deposit Insurance Corporation and made payable jointly to the owner and the Department of Insurance, or shall be written by an insurer as defined in this chapter, shall meet the specifications as may be required and defined in this chapter, and shall meet such specifications as may be required and approved by the department. The bond shall be conditioned upon the full and prompt payment of any bail bond issued by such professional bail agent into the court ordering the bond forfeited. The bond shall be to the people of the State of Mississippi in favor of any court of this state, whether municipal, justice, county, circuit, Supreme or other court.

(3) If any bond issued by a professional bail agent is declared forfeited and judgment entered thereon by a court of proper jurisdiction as authorized in Section 99-5-25, and the amount of the bond is not paid within ninety (90) days, that court shall order the department to declare the qualification bond of the professional bail agent to be forfeited and the license revoked. If the bond was not forfeited correctly under Section 99-5-25, it shall be returned to the court as uncollectible. The department shall then order the surety on the qualification bond to deposit with the court an amount equal to the amount of the bond issued by the professional bail agent and declared forfeited by the court, or the amount of the qualification bond, whichever is the smaller amount. The department shall, after hearing held upon not less than ten (10) days' written notice, suspend the license of the professional bail agent until such time as another qualification bond in the required amount is posted with the department. The revocation of the license of the professional bail agent shall also serve to revoke the license of each soliciting bail agent and bail enforcement agent employed or used by such professional bail agent. In the

event of a final judgment of forfeiture of any bail bond written under the provisions of this chapter, the amount of money so forfeited by the final judgment of the proper court, less all accrued court costs and excluding any interest charges or attorney's fees, shall be refunded to the bail agent or his insurance company upon proper showing to the court as to which is entitled to same, provided the defendant in such cases is returned to the sheriff of the county to which the original bail bond was returnable within eighteen (18) months of the date of such final judgment, or proof made of incarceration of the defendant in another jurisdiction, and that a "Hold Order" has been placed upon the defendant for return of the defendant to the sheriff upon release from the other jurisdiction, the return to the sheriff to be the responsibility of the professional bail agent, then the bond forfeiture shall be stayed and remission made upon petition to the court, in the amount found in the court's discretion to be just and proper. A bail agent licensed under this chapter shall have a right to apply for and obtain from the proper court an extension of time delaying a final judgment of forfeiture if such bail agent can satisfactorily establish to the court wherein such forfeiture is pending that the defendant named in the bail bond is lawfully in custody outside of the State of Mississippi.

(4) The qualification bond may be released by the department to the professional bail personal surety agent upon an order to release the qualification bond issued by a court of competent jurisdiction, or upon written request to the department by the professional bail personal surety agent no earlier than five (5) years after the expiration date of his last license.

HISTORY: Codes, 1942, § 8745-03; Laws, 1968, ch. 341, § 3; Laws, 1994, ch. 495, § 4; Laws, 1997, ch. 410, § 21; Laws, 1998, ch. 323, § 6; Laws, 1999, ch. 399, § 1; Laws, 2000, ch. 456, § 1; Laws, 2003, ch. 351, § 1; Laws, 2004, ch. 363, § 1; Laws, 2005, ch. 479, § 1; Laws, 2007, ch. 501, § 5; Laws, 2012, ch. 394, § 2; Laws, 2016, ch. 446, § 2, eff from and after July 1, 2016; reenacted and amended, Laws, 2018, ch. 362, § 2, eff from and after July 1, 2018.

Editor's Notes — Laws of 2016, ch. 446, § 4, was amended by Laws of 2018, ch. 362, § 4, to delete the July 1, 2018, repealer for this section.

Amendment Notes — The 2012 amendment rewrote (2).

The 2016 amendment designated the former first sentence of (1) as (1)(a); added (1)(b); designated the former second through fourth sentences of (1) as (2); designated the former fifth through eleventh sentences of (1) as (3); redesignated former (2) as (4); and deleted "as provided in subsection (2) of this section" following "be the responsibility of the professional bail agent" in the next-to-last sentence of (3).

The 2018 amendment substituted "eighteen (18) months" for "twelve (12) months" in the next-to-last sentence of (3).

§ 83-39-8. Managing and closing business upon death of personal surety.

If a professional bail agent who acts as a personal surety agent dies, the personal representative of the estate may contract with licensed professional bail agents, soliciting bail agents or bail enforcement agents to assist him in managing and closing the business affairs of the professional bail agent. The

licensed professional bail agent, soliciting bail agent or bail enforcement agent contracted by the personal representative may, on behalf of the personal representative, present defendants in court when required, assist in the apprehension and surrender of defendants to the court, or keep defendants under necessary surveillance. Nothing herein shall give the personal representative the authority to execute and sign bail bonds in connection with judicial proceedings.

HISTORY: Laws, 2007, ch. 501, § 1; Laws, 2012, ch. 394, § 3, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment rewrote the section.

§ 83-39-13. Annual financial statement; maintenance and registration of office physically located in Mississippi municipality or county required; Bail Bond Database.

(1) Each professional bail agent licensed under this chapter, under oath, shall provide to the Insurance Department an annual financial statement. The annual financial statement shall show assets, liabilities and net worth as of the end of the most recent calendar year. The statement shall be submitted annually to the department by June 1.

(2)(a) For purposes of applicable examinations, a professional bail agent licensed in this state shall maintain at least one (1) office physically located in any municipality or county in this state, to serve as his principal place of business operations where records pertaining to his bail agent business conducted in Mississippi are maintained and this office location shall be registered with the Insurance Department.

(b) When applying for an original or renewal license as a professional bail agent, the applicant shall indicate the address of the office location to serve as his principal place of business operations, and this address shall be evidenced on the face of the license issued to the licensee.

(c) If for any reason the professional bail agent changes the location of his principal place of business operations, removes to another state, or no longer continues in the profession as a bail agent, the bail agent shall register the new location with the department, or notify the department of his removal from the state or his cessation of business as a professional bail agent as appropriate.

(3) On or before October 1, 2016, the Mississippi Insurance Department shall establish a Bail Bond Database within the department for the reporting of all bail bonds written by personal surety agents and limited surety agents in this state. By November 15, 2016, each bail agent must input his or her bail bond information into the Bail Bond Database for all bonds written from and after October 1, 2016. By the fifteenth day of each subsequent month, each bail agent must update the Bail Bond Database regarding his or her bail bond information for bail bonds written from and after October 1, 2016, and each

update must be current through the last day of the previous month. Any bail agent who fails to comply with the provisions of this subsection (3) shall be assessed a fine in an amount not to exceed One Thousand Dollars ($1,000.00) per violation.

HISTORY: Codes, 1942, § 8745-05; Laws, 1968, ch. 341, § 5; Laws, 1984, ch. 436; Laws, 1994, ch. 495, § 7; Laws, 1998, ch. 323, § 7; Laws, 2011, ch. 463, § 5; Laws, 2016, ch. 446, § 3, eff from and after July 1, 2016; reenacted without change, Laws, 2018, ch. 362, § 3, eff from and after July 1, 2018.

Editor's Notes — Laws of 2016, ch. 446, § 4, was amended by Laws of 2018, ch. 362, § 4, to delete the July 1, 2018, repealer for this section.

Amendment Notes — The 2016 amendment rewrote (1), which read: "Each professional bail agent licensed under this chapter, under oath, shall report annually to the department on forms prescribed by the department. This report shall be made on a calendar basis before June 1 of each year"; substituted "with the Insurance Department" for "with the Department of Insurance" at the end of (2)(a); and added (3).

The 2018 amendment reenacted the section without change.

§ 83-39-15. Grounds for denial, suspension, revocation, and refusal to renew license.

(1) The department may deny, suspend, revoke or refuse to renew, as may be appropriate, a license to engage in the business of professional bail agent, soliciting bail agent, or bail enforcement agent for any of the following reasons:

(a) Any cause for which the issuance of the license would have been refused had it then existed and been known to the department.

(b) Failure to post a qualification bond in the required amount with the department during the period the person is engaged in the business within this state or, if the bond has been posted, the forfeiture or cancellation of the bond.

(c) Material misstatement, misrepresentation or fraud in obtaining the license.

(d) Willful failure to comply with, or willful violation of, any provision of this chapter or of any proper order, rule or regulation of the department or any court of this state.

(e) Conviction of felony or crime involving moral turpitude.

(f) Default in payment to the court should any bond issued by such bail agent be forfeited by order of the court.

(g) Being elected or employed as a law enforcement or judicial official.

(h) Engaging in the practice of law.

(i) Writing a bond in violation of Section 83-39-3(2) (b) (i) and (ii).

(j) Giving legal advice or a legal opinion in any form.

(k) Acting as or impersonating a bail agent without a license.

(*l*) Use of any other trade name than what is submitted on a license application to the department.

(m) Issuing a bail bond that contains information intended to mislead a court about the proper delivery by personal service or certified mail of a writ of scire facias, judgment nisi or final judgment.

(2) In addition to the grounds specified in subsection (1) of this section, the department shall be authorized to suspend the license, registration or permit of any person for being out of compliance with an order for support, as defined in Section 93-11-153. The procedure for suspension of a license, registration or permit for being out of compliance with an order for support, and the procedure for the reissuance or reinstatement of a license, registration or permit suspended for that purpose, and the payment of any fees for the reissuance or reinstatement of a license, registration or permit suspended for that purpose, shall be governed by Section 93-11-157 or 93-11-163, as the case may be. If there is any conflict between any provision of Section 93-11-157 or 93-11-163 and any provision of this chapter, the provisions of Section 93-11-157 or 93-11-163, as the case may be, shall control.

(3) In addition to the sanctions provided in this section, the department may assess an administrative fine in an amount not to exceed One Thousand Dollars ($1,000.00) per violation. Such administrative fines shall be in addition to any criminal penalties assessed under Section 99-5-1.

HISTORY: Codes, 1942, § 8745-06; Laws, 1968, ch. 341, § 6; Laws, 1994, ch. 495, § 8; Laws, 1996, ch. 507, § 89; Laws, 2001, ch. 563, § 2; Laws, 2010, ch. 466, § 3; Laws, 2014, ch. 479, § 2, eff from and after July 1, 2014.

Amendment Notes — The 2014 amendment added (1)(*l*), (1)(m), and (3).

§ 83-39-23. Notice to sheriff and judicial officials.

No sheriff or other official shall accept bond from a professional bail agent unless the bail agent is licensed under this chapter and unless the bail agent shall exhibit to the court a valid certificate or license issued by the department, and the license of the bail agent shall not have been suspended or revoked. The department shall provide notice to the sheriff and municipal law enforcement and to the courts of every county and municipality of any suspension or revocation of a professional, soliciting or bail enforcement license. The department, upon request, may furnish to any sheriff, district, circuit, county or justice court judge or municipal judge additional information which would appropriately identify the duly licensed professional bail agent and insurers whose operation is covered by this chapter.

HISTORY: Codes, 1942, § 8745-07; Laws, 1968, ch. 341, § 7; Laws, 1994, ch. 495, § 11; Laws, 2014, ch. 479, § 3, eff from and after July 1, 2014.

Amendment Notes — The 2014 amendment added the second sentence; in the last sentence, inserted "county or justice" following "district, circuit" and "judge" following "court"; and deleted "in the writing of bail" near the end.

§ 83-39-27. Prohibited activities.

It is unlawful for a licensee to engage in any of the following activities:

(a) Specify, suggest or advise the employment of any particular attorney to represent his principal.

(b) Pay a fee or rebate or give or promise to give anything of value to a jailer, policeman, peace officer, clerk, deputy clerk, any other employee of any court, district attorney or any of his employees or any person who has power to arrest or to hold any person in custody.

(c) Pay a fee or rebate or give anything of value to an attorney in bail bond matters, except in defense of any act on a bond, or as counsel to represent such bail agent, his agent or employees.

(d) Pay a fee or rebate or give or promise to give anything of value to the person on whose bond he is surety.

(e) Pay a fee or rebate or give or promise to give anything of value to any person, other than a soliciting bail agent, for the purpose of procuring a bail bond.

(f) Accept anything of value from a person on whose bond he is surety, or from others on behalf of such person, except the fee or premium on the bond, but the bail agent may accept collateral security or other indemnity.

(g) Coerce, suggest, aid and abet, offer promise of favor or threaten any person on whose bond he is surety or offers to become surety, to induce that person to commit any crime.

(h) Give legal advice or a legal opinion in any form.

(i) Refuse to return collateral security or other indemnity when the fee or premium on the bond has been fully paid or when the bail agent's obligation on the bond has been terminated.

HISTORY: Codes, 1942, § 8745-09; Laws, 1968, ch. 341, § 9; Laws, 1994, ch. 495, § 13; Laws, 2001, ch. 320, § 1; brought forward without change, Laws, 2010, ch. 466, § 5; Laws, 2011, ch. 463, § 7; Laws, 2012, ch. 394, § 4, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment added (i).

§ 83-39-29. Penalties.

(1) The department may provide information to the district attorney in the district in which a professional bail agent, a soliciting bail agent or bail enforcement agent is domiciled so that proper legal action may be pursued against any licensee who is alleged to have violated any provision of Chapter 39, Title 83. Such licensee is guilty of a misdemeanor and shall be subject to a fine of not more than One Thousand Dollars ($1,000.00), imprisonment in the county jail for not more than one (1) year, or both. Any insurer violating any provision of Chapter 39, Title 83 may be fined in an amount not to exceed Fifty Thousand Dollars ($50,000.00).

(2) Any person or entity who acts or attempts to solicit, write or present a bail bond as a professional bail agent, soliciting bail agent, or bail enforcement agent as defined in this chapter and who is not licensed under this chapter is guilty of a misdemeanor and, upon conviction, shall be subject to a fine of not more than One Thousand Dollars ($1,000.00), imprisonment in the county jail for not more than one (1) year, or both.

(3) Any person who acts or attempts to act, represents himself to be, or impersonates a professional bail agent, a soliciting bail agent or a bail

enforcement agent as defined in this chapter by attempting to arrest or detaining any person, and who is not licensed under this chapter, is guilty of a misdemeanor and, upon conviction, shall be subject to a fine of not more than Five Thousand Dollars ($5,000.00), imprisonment for not more than one (1) year, or both.

(4) A bail agent, bail enforcement agent or bail enforcement agent from another state shall report to the sheriff's department of the county in which he is attempting to locate a fugitive prior to beginning to look for the fugitive to prove his licensing and legal right to the fugitive. Failure to prove licensing shall be an offense punishable by a fine not to exceed One Thousand Dollars ($1,000.00).

(5) Any person charged with a criminal violation who has obtained his release from custody by having a professional bail agent, insurer, agent of a bail agent or insurer, or any person other than himself furnish his bail bond and who fails to appear in court, at the time and place ordered by the court, is guilty of "bond jumping" and, upon conviction, shall be subject to a fine of not more than One Thousand Dollars ($1,000.00), imprisonment in the county jail for not more than one (1) year, or both, and payment of restitution for reasonable expenses incurred returning the defendant to court.

(6) Any person who knowingly and intentionally aids and abets any person in the commission of the offense of bond jumping, whether the person committing the principal offense is actually convicted, shall be guilty of aiding and abetting bond jumping and, upon conviction, shall be subject to a fine of not more than One Thousand Dollars ($1,000.00) or imprisonment in the county jail for not more than one (1) year, or both, and payment of restitution for reasonable expenses incurred in returning the defendant to court. Any person who is convicted of aiding and abetting shall be jointly and severally liable for payment of restitution for reasonable expenses incurred in returning the defendant to court.

(7) Any bail agent who is prejudiced or injured by the commission of any of the offenses set forth in this section shall have standing to file a complaint alleging the commission of the offense or offenses.

HISTORY: Codes, 1942, §§ 8745-09, 8745-10; Laws, 1968, ch. 341, §§ 9, 10; Laws, 1994, ch. 495, § 14; Laws, 1994, ch. 634, § 2; Laws, 2003, ch. 466, § 1; Laws, 2005, ch. 412, § 1; Laws, 2009, ch. 520, § 2; brought forward without change, Laws, 2010, ch. 466, § 6; Laws, 2014, ch. 479, § 5, eff from and after July 1, 2014.

Amendment Notes — The 2014 amendment inserted "or entity" following "Any person" at the beginning of (2) and made two minor punctuation changes in (1).

§ 83-39-30. Prohibited activities; illegal business referrals.

(1) Any person licensed under this chapter who pays or gives anything of value, either directly or indirectly, to any law enforcement or judicial official or any employee of any facility where defendants who are or may be eligible for bail are detained or may post bail for the purpose of enticing that official or employee to refer business in any manner to them shall be guilty of a felony

subject to imprisonment for not more than five (5) years or a fine of not more than Fifty Thousand Dollars ($50,000.00), or both. Nothing in this section shall prohibit a bail agent from making political contributions to persons running for public office.

(2) Any person licensed under this chapter who pays or gives anything of value, either directly or indirectly, or who solicits another person to pay or give anything of value to any convicted inmate or trustee, regardless of whether they are held pretrial or post-conviction in any facility where defendants who are or may be eligible for bail are detained or may post bail for the purpose of enticing that convicted inmate or trustee to refer business in any manner to them shall be guilty of a felony subject to imprisonment for not more than five (5) years or a fine of not more than Fifty Thousand Dollars ($50,000.00), or both.

(3) Any person who is convicted under this section shall have their license permanently revoked and may not be involved in any bail business in any way.

HISTORY: Laws, 2014, ch. 479, § 6, eff from and after July 1, 2014.

CHAPTER 41.

HOSPITAL AND MEDICAL SERVICE ASSOCIATIONS AND CONTRACTS

Article 5. Provisions Common to Hospital, Medical, or Surgical Insurance. 83-41-201
Article 7. Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act. 83-41-301

ARTICLE 5.

PROVISIONS COMMON TO HOSPITAL, MEDICAL, OR SURGICAL INSURANCE.

Sec.
83-41-219. Reciprocal time limitations on health insurance claim filing and claim audits; applicability [See Editor's Note for effective date and applicability].

§ 83-41-219. Reciprocal time limitations on health insurance claim filing and claim audits; applicability [See Editor's Note for effective date and applicability].

(1) If any health insurance issuer or other health insurance benefit payer limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer or other health insurance benefit payer shall have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the

claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim.

(2) If any health insurance issuer or other health insurance benefit payer does not limit the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer or other health insurance benefit payer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve (12) months after the payment of an invalid or overpaid claim.

(3) Nothing in this section shall apply to:

(a) Audits that were opened before July 1, 2012;

(b) Audits of pharmacies as provided in Section 73-21-175 et seq.;

(c) Claims submitted by providers for reimbursement under the Mississippi Medicaid Program, except that all audits of claims and payments made by or on behalf of the Division of Medicaid are limited to a maximum of five (5) years after final filing of the claim; and

(d) Claims submitted in the context of misrepresentation, omission, concealment, or fraud by the health care provider or other person.

HISTORY: Laws, 2010, ch. 393, § 1; Laws, 2012, ch. 532, § 1, eff from and after July 1, 2012.

Editor's Notes — Laws of 2010, ch. 393, § 2 provides:

"SECTION 2. This act shall take effect and be in force from and after July 1, 2010, and shall apply to health care claims submitted for payment on or after that date."

Amendment Notes — The 2012 amendment deleted former (3), which read: "Nothing in this section shall apply to claims submitted in the context of misrepresentation, omission, concealment, or fraud by the health care provider or other person"; and redesignated former (4) as (3), and rewrote the subsection, which read: "Nothing in this section shall apply to an audit of a pharmacy as provided in Section 73-21-175 et seq., nor to claims submitted by providers for reimbursement under the Mississippi Medicaid Program."

ARTICLE 7.

HEALTH MAINTENANCE ORGANIZATION, PREFERRED PROVIDER ORGANIZATION AND OTHER PREPAID HEALTH BENEFIT PLANS PROTECTION ACT.

Sec.

83-41-337. Examination of health maintenance organizations and providers; acceptance of reports in lieu of examinations.

§ 83-41-337. Examination of health maintenance organizations and providers; acceptance of reports in lieu of examinations.

(1) The commissioner shall make an examination of the affairs of any health maintenance organization and providers with whom such organization

has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every five (5) years at the expense of the health maintenance organization and provider with whom the health maintenance organization has contracted according to relevant statutes which govern examinations of insurance companies under the insurance laws of this state.

(2) The State Health Officer may make an examination concerning the quality assurance program of the health maintenance organization and of any providers with whom such organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every five (5) years.

(3) Every health maintenance organization and provider shall submit its books and records for such examinations and in every way facilitate the completion of the examination. For the purpose of examinations, the commissioner and the State Health Officer may administer oaths to, and examine the officers and agents of, the health maintenance organization and the principals of providers concerning their business as per existing insurance laws, rules and regulations.

(4) The expenses of examinations under this section shall be assessed against the health maintenance organization being examined as per existing laws for examination of insurance companies or the State Health Officer for whom the examination is being conducted.

(5) In lieu of such examination, the commissioner or State Health Officer may accept the report of an examination made by the Commissioner of Insurance or the State Health Officer of another state.

HISTORY: Laws, 1995, ch. 613, § 19; Laws, 2012, ch. 364, § 3, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment substituted "five (5)" for "three (3)" preceding "years" throughout the section.

CHAPTER 49.
LEGAL EXPENSE INSURANCE

Sec.
83-49-27. Retention of records; inspection and report; expenses.

§ 83-49-27. Retention of records; inspection and report; expenses.

(1) The commissioner shall require every sponsor of a prepaid legal services plan to retain at the address shown on its license the plan-related books, records, accounts and vouchers for a term of five (5) years beginning immediately after the completion of the transaction and kept in such manner that the commissioner or his authorized representatives may readily verify its

annual statements and determine whether the plan and the sponsor are in compliance with the law.

(2) The commissioner, or his designee, as often as the commissioner, in his sole discretion, deems appropriate but, at a minimum, at least every five (5) years shall visit each sponsor of a prepaid legal services plan and examine into such of its affairs as relate to the business of operating the plan. The commissioner shall have free access to all plan-related books, records, accounts and vouchers of the plan and may summon and examine under oath officers, trustees, agents and employees of the plan and any other persons regarding the affairs and condition of the plan. Provided, that no information, written or oral, need be supplied under this or any other subsection of this chapter in violation of the attorney-client privilege as it is construed by the courts of this state.

(3) Every sponsor of a plan being examined, its officers, employees and agents shall produce and make freely accessible to the commissioner the accounts, records, documents and files in its possession or control relating to the subject of the examination. Such officers, employees and agents shall facilitate such examination and aid the examiners as far as it is in their power in making the examination.

(4)(a) The commissioner shall make a full written report of each examination made by him containing only facts ascertained from the accounts, records and documents examined and from the sworn testimony of witnesses.

(b) The commissioner shall furnish a copy of the proposed report to the sponsor of the plan examined not less than twenty (20) days prior to filing the report. If such plan so requests in writing within such twenty-day period, or such longer period as the commissioner may grant, the commissioner shall grant a hearing with respect to the report, and shall not so file the report until after the hearing and such modifications have been made therein as the commissioner may deem proper.

(c) The commissioner may withhold from public inspection the report of any examination or investigation for so long as he deems it to be in the public interest or necessary to protect the plan examined from unwarranted injury.

(d) After the report has been filed, the commissioner may publish the report or the results thereof in one or more newspapers published in this state if he should deem it to be in the public interest.

(5) The sponsor of the plan so examined shall pay, at the direction of the commissioner, all the actual travel and living expenses of such examination. When the examination is made by an examiner who is not a regular employee of the department, the sponsor examined shall pay the proper charges for the services of the examiner and his assistants in an amount approved by the commissioner. A consolidated account for the examination shall be filed by the examiner with the commissioner. No sponsor or other entity shall pay and no examiner shall accept any additional emolument on account of any examination. When the examination is conducted, in whole or in part, by regular salaried employees of the Department of Insurance, payment for such services

and proper expenses shall be made by the sponsor examined to the commissioner, and such payment shall be deposited with the State Treasurer to the account of the Department of Insurance.

HISTORY: Laws, 1983, ch. 474, § 14; Laws, 1991, ch. 573, § 123; Laws, 2012, ch. 364, § 4, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment substituted "five (5)" for "three (3)" following "for a term of" in (1); rewrote the first sentence in (2); and substituted "Department of Insurance" for "Insurance Department" twice in (5).

CHAPTER 51.

DENTAL CARE BENEFITS

General Provisions. 83-51-1
Prohibitions Against Certain Provisions In Contracts Between Certain Health Care Entities and Dentists. 83-51-31

GENERAL PROVISIONS

Sec.
83-51-1. Definitions.
83-51-15. Denial of claims; appeal; prior authorization.

§ 83-51-1. Definitions.

As used in this chapter, the following words have the meanings ascribed herein unless the context clearly requires otherwise:

(a) "Health insurance policy" means any individual, group, blanket or franchise insurance policy, insurance agreement or group hospital service contract which provides benefits for dental care expenses incurred as a result of an accident or sickness.

(b) "Employee benefit plan" means any plan, fund or program heretofore or hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, dental care benefits in the event of accident or sickness.

(c) "Dental care services" means those general and usual services furnished to any person for the purpose of preventing, alleviating, curing or healing human dental illness or injury as defined in Sections 73-9-1 through 73-9-65, Mississippi Code of 1972.

(d) "Dentist" means any person who furnishes dental care services and who is licensed as a dentist by the State of Mississippi.

(e) "Dental service contractor" means any person who accepts a prepayment from or for the benefit of any other person or group of persons as consideration for providing to such person or group of persons the opportunity to receive dental services at such times in the future as such services

may be appropriate or required, but shall not be construed to include a dentist or professional dental corporation that accepts prepayment on a fee-for-service basis for providing specific dental services to individual patients for whom such services have been prediagnosed. Nothing in this paragraph (e) shall apply to a funded or self-funded trust qualified with the United States Department of Labor in accordance with Public Law 93-406, or the Division of Medicaid or any contractor of the division when providing services to eligible Medicaid beneficiaries.

(f) "Participant" means a dentist who has contracted with a dental service contractor to accept from and to look solely to such contractor for payment for any health care services rendered to a subscriber, subject to any co-payment obligations included in the contract of the subscriber with the dental service contractor.

(g) "Person" means an individual, insurer, association, organization, partnership, business, trust, except Employee Retirement Income Security Act (E.R.I.S.A.) trusts qualified with the United States Department of Labor under Public Law 93-406, corporation, or other legal entity.

(h) "Subscriber" means any person by or for whom a dental service contractor is paid a periodic premium as prepayment for dental services to be rendered to him by a participant.

(i) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

HISTORY: Laws, 1985, ch. 369, § 1, eff from and after July 1, 1985; Laws, 2019, ch. 342, § 1, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment added (e) through (i); and made minor punctuation changes.

Federal Aspects — Employee Retirement Income Security Act (E.R.I.S.A.) generally, see 29 USCS § 1001 et seq.

OPINIONS OF THE ATTORNEY GENERAL

The Dental Care Benefits Law (Section 83-51-1 et seq.) is inapplicable to the Children's Health Insurance Program (CHIP), which is not under the jurisdiction of the Department of Insurance, but was, pursuant to Section 41-86-9, developed by the Children's Health Insurance Program Commission; thus, the School Employees Health Insurance Management Board (HIMB) is not prohibited from requiring that dentists meet certain minimum requirements in order to receive reimbursement for services rendered to children under CHIP, nor is HIMB prohibited from requiring that dentists participate in a provider network in order to receive reimbursement for services rendered to children under CHIP. Anderson and Dale, Dec. 6, 2002, A.G. Op. #02-0433.

§ 83-51-15. Denial of claims; appeal; prior authorization.

(1)(a) A dental service contractor or a contract of dental insurance shall establish and maintain appeal procedures for any claim by a dentist or a subscriber that is denied based upon lack of medical necessity.

(b) Any denial shall be based upon a determination by a dentist who

holds a nonrestricted license issued in the United States in the same or an appropriate specialty that typically manages the dental condition, procedure, or treatment under review.

(c) Subsequent to an initial denial, the licensed dentist making the adverse determination shall not be an employee of the dental service contractor or dental insurer.

(d) Any written communication to an insured or a dentist that includes or pertains to a denial of benefits for all or part of a claim on the basis of a lack of medical necessity shall include the name, applicable specialty designation, license number together with state of issuance, and the email address of the licensed dentist making the adverse determination.

(2)(a) For the purposes of this subsection, a "prior authorization" shall mean any predetermination, prior authorization or similar authorization that is verifiable, whether through issuance of letter, facsimile, e-mail or similar means, indicating that a specific procedure is, or multiple procedures are, covered under the patient's plan and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a dentist using a prescribed format.

(b) A dental service contractor shall not deny any claim subsequently submitted for procedures specifically included in a prior authorization unless at least one (1) of the following circumstances applies for each procedure denied:

(i) Benefit limitations such as annual maximums and frequency limitations not applicable at the time of prior authorization are reached due to utilization subsequent to issuance of the prior authorization;

(ii) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

(iii) If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;

(iv) If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time require disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued; or

(v) The dental service contractor's denial is because of one (1) of the following:

1. Another payor is responsible for the payment;

2. The dentist has already been paid for the procedures identified on the claim;

3. The claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the dental service contractor by the dentist, patient, or other person not related to the carrier; or

4. The person receiving the procedure was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

(c) A dental service contractor shall not require any information be submitted for a prior authorization request that would not be required for submission of a claim.

(d) A dental service contractor shall issue a prior authorization within thirty (30) days of the date a request is submitted by a dentist.

(e) The provisions of subsection (1) of this section shall apply to any denial of a claim pursuant to paragraph (b) of this subsection for a procedure included in a prior authorization.

(3) A contractor shall not recoup a claim solely due to a patient's loss of coverage or ineligibility if, at the time of treatment, the contractor erroneously confirms coverage and eligibility, but had sufficient information available to it indicating that the patient was no longer covered or was ineligible for coverage.

HISTORY: Laws, 2019, ch. 342, § 2, eff from and after July 1, 2019.

PROHIBITIONS AGAINST CERTAIN PROVISIONS IN CONTRACTS BETWEEN CERTAIN HEALTH CARE ENTITIES AND DENTISTS

Sec.

83-51-31. Prohibition against contract between certain health care entities and dentists from requiring that dentist provide services to subscribers at fee established by health care entity unless services are covered services under subscriber agreement.

§ 83-51-31. Prohibition against contract between certain health care entities and dentists from requiring that dentist provide services to subscribers at fee established by health care entity unless services are covered services under subscriber agreement.

No contract between a health care entity that offers a dental plan or plans and a dentist for the provision of services to subscribers may require that a dentist provide services to his subscribers at a fee set by the health care entity unless the services are covered services under the applicable subscriber agreement. For the purposes of this section, "covered services" means services that are reimbursable under the applicable subscriber agreement, notwithstanding any deductibles, waiting periods or frequency limitations that may apply. For the purposes of this section, "dental plan" means any policy of insurance that is issued by a health care entity that provides for coverage of dental services not in connection with a medical plan.

HISTORY: Laws, 2010, ch. 497, § 1; Laws, 2012, ch. 318, § 1, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment deleted the (1) designation and former (2) which made the section repealed July 1, 2012.

CHAPTER 52.

GUARANTEED ASSET PROTECTION WAIVERS

Sec.

83-52-1. Chapter purpose; applicability; waivers are not insurance and are exempt from insurance laws.
83-52-3. Definitions.
83-52-5. Offering, selling or providing GAP waivers to Mississippi borrowers authorized.
83-52-7. Insurance policies insuring GAP waivers; coverage to cover subsequent assignees; coverage to remain in effect unless cancelled or terminated.
83-52-9. Guaranteed asset protection waiver disclosures.
83-52-11. Guaranteed asset protection waiver agreement cancellation.
83-52-13. Inapplicability of Sections 83-52-5(3), 83-52-9 and 83-52-15 to certain GAP waivers.
83-52-15. Enforcement of this chapter and protection of Mississippi GAP waiver holders.

§ 83-52-1. Chapter purpose; applicability; waivers are not insurance and are exempt from insurance laws.

(1) The purpose of this chapter is to provide a framework within which guaranteed asset protection waivers are defined and may be offered within this state.

(2) This chapter does not apply to:

(a) An insurance policy offered by an insurer under the insurance laws of this state; or

(b) A debt cancellation or debt suspension contract being offered by any national or state-chartered bank or federal or state-chartered credit union in compliance with 12 CFR Part 37, or 12 CFR Part 721, or any other federal law.

(3) Guaranteed asset protection waivers governed under this chapter are not insurance and are exempt from the insurance laws of this state. Persons marketing, selling or offering to sell guaranteed asset protection waivers to borrowers who comply with this chapter are exempt from insurance licensing and insurance regulation requirements of this state.

HISTORY: Laws, 2018, ch. 417, § 1, eff from and after July 1, 2018.

§ 83-52-3. Definitions.

The following are terms defined for purposes of this chapter and are not intended to provide actual terms required in guaranteed asset protection waivers:

(a) "Administrator" means a person, other than an insurer or creditor, who issues, makes or provides a GAP waiver, or who performs administra-

tive or operational functions pursuant to guaranteed asset protection waiver programs.

(b) "Borrower" means a debtor, retail buyer or lessee, under a finance agreement.

(c) "Commissioner" means the Commissioner of Insurance for the State of Mississippi.

(d) "Creditor" means:

(i) The lender in a loan or credit transaction;

(ii) The lessor in a lease transaction;

(iii) Any "retail seller" of motor vehicles that provides credit to "retail buyers" of such motor vehicles provided that such entities comply with the provisions of this chapter;

(iv) The seller in commercial retail installment transactions; or

(v) The assignees of any of the creditors listed in subparagraphs (i) through (iv) of this paragraph to whom the credit obligation is payable.

(e) "Finance agreement" means a loan, lease or retail installment sales contract for the purchase or lease of a motor vehicle or any other credit extension secured by a motor vehicle.

(f) "Free look period" means the period of time from the effective date of the GAP waiver until the date the borrower may cancel the contract without penalty, fees or costs to the borrower. This period of time shall not be shorter than thirty (30) days.

(g) "Guaranteed asset protection waiver" or "GAP waiver" means a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive, or an administrator agrees for a separate charge to pay, all or part of amounts due on a borrower's finance agreement in the event of a total physical damage loss or unrecovered theft of the motor vehicle. A GAP waiver in which the creditor cancels or waives amount due shall be part of, or a separate addendum to, the finance agreement.

(h) "Insurer" means an insurance company licensed, registered, or otherwise authorized to do business under the insurance laws of this state.

(i) "Motor vehicle" means self-propelled or towed vehicles designed for personal or commercial use, including, but not limited to, automobiles, trucks, motorcycles, recreational vehicles, all-terrain vehicles, snowmobiles, campers, boats, personal watercraft, and motorcycle, boat, camper and personal watercraft trailers.

(j) "Person" includes an individual, company, association, organization, partnership, business trust, corporation, and every form of legal entity.

HISTORY: Laws, 2018, ch. 417, § 2, eff from and after July 1, 2018.

§ 83-52-5. Offering, selling or providing GAP waivers to Mississippi borrowers authorized.

(1) GAP waivers may be offered, sold or provided to borrowers in this state under this chapter.

(2) GAP waivers may, at the option of the creditor or administrator, be

sold for a single payment or may be offered with a monthly or periodic payment option.

(3) Notwithstanding any other provision of law to the contrary, any cost to the borrower for a guaranteed asset protection waiver entered into in compliance with the Truth in Lending Act (15 USC 1601 et seq.) and its implementing regulations, as they may be amended from time to time, shall be separately stated and is not to be considered a finance charge or interest.

(4) A retail seller or administrator shall insure its GAP waiver obligations under a contractual liability or other insurance policy issued by an insurer. A creditor, other than a retail seller, may insure its GAP waiver obligations under a contractual liability policy or other such policy issued by an insurer. Any such insurance policy may be directly obtained by a creditor, retail seller, or may be procured by an administrator to cover a creditor's or retail seller's obligations. However, retail sellers that are lessors on motor vehicles are not required to insure obligations related to GAP waivers on such leased vehicles.

(5) The GAP waiver shall remain a part of the finance agreement upon the assignment, sale or transfer of such finance agreement by the creditor.

(6) Neither the extension of credit, the term of credit, nor the term of the related motor vehicle sale or lease may be conditioned upon the purchase of a GAP waiver.

(7) Any creditor or administrator that offers a GAP waiver shall report the sale of, and forward funds received on all such waivers to the designated party, if any, as prescribed in any applicable administrative services agreement, contractual liability policy, other insurance policy or other specified program documents.

(8) Funds received or held by a creditor or administrator and belonging to an insurer, creditor or administrator, pursuant to the terms of a written agreement, shall be held by such creditor or administrator in a fiduciary capacity.

HISTORY: Laws, 2018, ch. 417, § 3, eff from and after July 1, 2018.

Cross references. — This section is not applicable to a guaranteed asset protection waiver offered in conjunction with a lease or retail installment sale associated with a commercial transaction, see § 83-52-13.

§ 83-52-7. Insurance policies insuring GAP waivers; coverage to cover subsequent assignees; coverage to remain in effect unless cancelled or terminated.

(1) Contractual liability or other insurance policies insuring GAP waivers shall state the obligation of the insurer to reimburse or pay to the creditor or administrator any sums the creditor is legally obligated to waive, or administrator is legally obligated to pay, under the GAP waivers issued by the creditor or administrator and purchased or held by the borrower.

(2) Coverage under a contractual liability or other insurance policy insuring a GAP waiver shall also cover any subsequent assignee upon the assignment, sale or transfer of the finance agreement.

(3) Coverage under a contractual liability or other insurance policy insuring a GAP waiver shall remain in effect unless cancelled or terminated in compliance with applicable insurance laws of this state.

(4) The cancellation or termination of a contractual liability or other insurance policy shall not reduce the insurer's responsibility for GAP waivers issued by the creditor or administrator prior to the date of cancellation or termination and for which the premium has been received by the insurer.

HISTORY: Laws, 2018, ch. 417, § 4, eff from and after July 1, 2018.

§ 83-52-9. Guaranteed asset protection waiver disclosures.

Guaranteed asset protection waivers shall disclose, as applicable, in writing and in clear, understandable language that is easy to read, the following:

(a) The name and address of the initial creditor and the borrower at the time of sale, and the identity of any administrator if different from the creditor.

(b) The purchase price and the terms of the GAP waiver, including, without limitation, the requirements for protection, conditions, or exclusions associated with the GAP waiver.

(c) That the borrower may cancel the GAP waiver within a free look period as specified in the waiver, and will be entitled to a full refund of the purchase price, so long as no benefits have been provided.

(d) The procedure the borrower shall follow, if any, to obtain GAP waiver benefits under the terms and conditions of the waiver, including a telephone number and address where the borrower may apply for waiver benefits.

(e) Whether or not the GAP waiver is cancellable after the free look period and the conditions under which it may be cancelled or terminated, including the procedures for requesting any refund due.

(f) That in order to receive any refund due in the event of a borrower's cancellation of the GAP waiver agreement or early termination of the finance agreement after the free look period of the GAP waiver, the borrower, in accordance with terms of the waiver, shall provide a written request to cancel to the creditor, administrator or such other party. If the GAP waiver is cancelled due to the early termination of the finance agreement, the borrower must provide the request within ninety (90) days of the occurrence of the event terminating the finance agreement.

(g) The methodology for calculating any refund of the unearned purchase price of the GAP waiver due, in the event of cancellation of the GAP waiver or early termination of the finance agreement.

(h) That neither the extension of credit, the terms of the credit, nor the terms of the related motor vehicle sale or lease, may be conditioned upon the purchase of the GAP waiver.

HISTORY: Laws, 2018, ch. 417, § 5, eff from and after July 1, 2018.

Cross References — This section is not applicable to a guaranteed asset protection waiver offered in conjunction with a lease or retail installment sale associated with a commercial transaction, see § 83-52-13.

§ 83-52-11. Guaranteed asset protection waiver agreement cancellation.

(1) Guaranteed asset protection waiver agreements may be cancellable or noncancellable after the free look period. GAP waivers shall provide that if a borrower cancels a waiver within the free look period, the borrower will be entitled to a full refund of the purchase price, so long as no benefits have been provided; or in the event benefits have been provided, the borrower may receive a full or partial refund pursuant to the terms of the waiver.

(2) In the event of a borrower's cancellation of the GAP waiver or early termination of the finance agreement, after the agreement has been in effect beyond the free look period, the borrower may be entitled to a refund of any unearned portion of the purchase price of the waiver unless the waiver provides otherwise. In order to receive a refund, the borrower, in accordance with any applicable terms of the waiver, shall provide a written request to the creditor, administrator or other party. If the GAP waiver is cancelled due to the early termination of the finance agreement, the borrower must provide the request within ninety (90) days of the event terminating the finance agreement.

(3) If the cancellation of a GAP waiver occurs as a result of a default under the finance agreement or the repossession of the motor vehicle associated with the finance agreement, or any other termination of the finance agreement, any refund due may be paid directly to the creditor or administrator and applied as set forth in subsection (4) of this section.

(4) Any cancellation refund under subsection (1), (2) or (3) of this section may be applied by the creditor as a reduction of the amount owed under the finance agreement, unless the borrower can show that the finance agreement has been paid in full.

HISTORY: Laws, 2018, ch. 417, § 6, eff from and after July 1, 2018.

§ 83-52-13. Inapplicability of Sections 83-52-5(3), 83-52-9 and 83-52-15 to certain GAP waivers.

Sections 83-52-5(3), 83-52-9 and 83-52-15 of this chapter are not applicable to a guaranteed asset protection waiver offered in connection with a lease or retail installment sale associated with a commercial transaction.

HISTORY: Laws, 2018, ch. 417, § 7, eff from and after July 1, 2018.

§ 83-52-15. Enforcement of this chapter and protection of Mississippi GAP waiver holders.

The commissioner may take action which is necessary or appropriate to enforce the provisions of this chapter and to protect guaranteed asset protec-

tion waiver holders in this state. After proper notice and opportunity for hearing, the commissioner may:

(a) Order the creditor, administrator or any other person not in compliance with this chapter to cease and desist from further guaranteed asset protection waiver-related operations which are in violation of this chapter.

(b) Impose a penalty of not more than Five Hundred Dollars ($500.00) per violation and not more than Ten Thousand Dollars ($10,000.00) in the aggregate for all violations of similar nature. For purposes of this paragraph (b), violations shall be of a similar nature if the violation consists of the same or similar course of conduct, action, or practice, irrespective of the number of times the conduct, action, or practice which is determined to be a violation of this chapter occurred.

HISTORY: Laws, 2018, ch. 417, § 8, eff from and after July 1, 2018.

Cross References — This section is not applicable to a guaranteed asset protection waiver offered in conjunction with a lease or retail installment sale associated with a commercial transaction, see § 83-52-13.

CHAPTER 53.

CREDIT LIFE AND CREDIT DISABILITY INSURANCE

Sec.
83-53-25. Limitation upon compensation in connection with insurance contract.

§ 83-53-25. Limitation upon compensation in connection with insurance contract.

(1) No one shall pay, accrue, credit or otherwise allow, either directly or indirectly, any compensation to any creditor, person, partnership, corporation, association or other entity in connection with any policy, certificate or other contract of credit life insurance or credit disability insurance which exceeds forty-five percent (45%) of the premium rates approved for such policy, certificate or contract.

(2) "Compensation," as used herein, shall include, but not be limited to, all of the following:

(a) Commission, fees and expense allowances;

(b) The fair market value of all equipment, calculators, goods and services;

(c) The fair market value of benefits such as travel, vacations or other rewards of any kind; and

(d) All other accruals, payments and other compensation or expenditures in any form whatsoever.

(3) "Compensation" shall not include:

(a) Bona fide corporate dividends paid or accrued by an insurance company to a stockholder;

(b) Bona fide compensation paid to or reimbursement of expenses

incurred by a director, officer or employee of an insurance company for the performance of the corporate duties of any such director, officer or employee;

(c) Experience refunds paid, allocated or accrued by an insurer pursuant to a written experience refund agreement which are paid only with respect to earned premiums produced by or attributable to the creditor or licensed agent designated to receive such experience refund; provided, however, that:

(i) All such experience refund agreements shall be on a form approved in writing by the commissioner;

(ii) All such experience refunds shall be calculated using only accounting methods approved by the commissioner;

(iii) All such experience refund calculations shall be made in accordance with the requirements of a form prescribed by the commissioner which form shall provide, among other things, for the deduction of claims incurred, premium taxes earned, compensation paid or earned and expenses incurred during the preceding calendar year, all of which shall be determined in a manner acceptable to the commissioner; and

(iv) All such experience refunds shall be paid annually within thirty (30) days following the filing of the insurer's annual statement with the Department of Insurance;

(d) Corporate allocations or dividends paid, allocated or accrued by an insurer or insurance holding company from any part of the assets, income, earnings, profits or losses of any corporation, insurer or other legal entity with respect to any class or series of stock, or other equity interest, in the insurer or insurance holding company, including payments for the redemption or purchase by the issuer of such shares or other equity interest.

(4) The commissioner is hereby vested with full authority as provided by Section 83-53-29 to regulate, reduce and/or adjust experience refunds or corporate allocations in accordance with the provisions of paragraphs (c) and (d) of subsection (3) of this section.

HISTORY: Laws, 1986, ch. 440, § 13; Laws, 1989, ch. 492, § 1; Laws, 2014, ch. 389, § 1, eff from and after July 1, 2014.

Amendment Notes — The 2014 amendment substituted "earned" for "incurred" and "or earned" for "(as defined herein)" in (3)(c)(iii).

CHAPTER 58.

NEW HOME WARRANTY ACT

Sec.
83-58-3. Definitions.
83-58-5. Builder's warranties to owner.

§ 83-58-3. Definitions.

For purposes of this chapter the following words and phrases shall have the meanings ascribed herein unless the context clearly indicates otherwise:

(a) "Builder" means any person, corporation, partnership, or other entity which constructs a home or engages another to construct a home, including a home occupied initially by its builder as his residence, for the purpose of sale.

(b) "Building standards" means the standards contained in the building code, mechanical-plumbing code, and electrical code in effect in the county, municipality or other local political subdivision where a home is to be located, at the time construction of that home is commenced, or, if the county, city or other local political subdivision has not adopted such codes, the Standard Building Code, together with any additional performance standards, if any, which the builder may undertake to be in compliance.

(c) "Home" means any new structure designed and used only for residential use.

(d) "Initial purchaser" means any person for whom a home is built or the first person to whom a home is sold upon completion of construction.

(e) "Major structural defect" means actual physical damage to any of the following load-bearing portions of a home caused by failure of the load-bearing portions and its load-bearing functions, as follows to wit:

(i) Foundation systems and footings;

(ii) Beams;

(iii) Girders;

(iv) Lintels;

(v) Columns;

(vi) Load-bearing walls and partitions;

(vii) Floor systems;

(viii) Roof-framing systems.

(f) "Owner" means the initial purchaser of a home and any of his successors in title to a home during the time the warranties provided under this chapter are in effect.

(g) "Warranty commencement date" means the date that legal title to a home is conveyed to its initial purchaser or the date the home is first occupied, whichever occurs first.

HISTORY: Laws, 1997, ch. 465, § 2; Laws, 2012, ch. 405, § 1, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment in (e), deleted "any" preceding "actual physical damage to," inserted "any of" thereafter, deleted "designated" following "the following," and inserted "and its" preceding "load-bearing functions"; and inserted "Load-bearing" at the beginning of (e)(vi).

JUDICIAL DECISIONS

ANALYSIS

2. Limitations period.
3. Builder.

2. Limitations period.

Claim by homeowners against a builder under the New Home Warranty Act, Miss. Code Ann. § 83-58-1 et seq., for structural

defects in the homeowners' home, was time-barred because (1) the claim had to be filed within six years of the home's first occupation, under Miss. Code Ann. §§ 83-58-5(1)(b), and 83-58-3(g), and (2) the home was first occupied over six years before suit was filed. Townes v. Rusty Ellis Builder, Inc., 98 So. 3d 1046, 2012 Miss. LEXIS 483 (Miss. 2012).

3. Builder.

Trial court properly granted summary judgment in favor of the sole member of a limited liability company (LLC) in homeowners' action alleging negligence and breach of warranty because the member was not personally liable for the defects in their home; the LLC was the builder of the home, not the member. Brown v. Waldron, 186 So. 3d 955, 2016 Miss. App. LEXIS 115 (Miss. Ct. App. 2016).

§ 83-58-5. Builder's warranties to owner.

(1) Subject to the exclusions provided in this section, every builder warrants the following to the owner:

(a) One (1) year following the warranty commencement date, the home will be free from any defect due to noncompliance with the building standards.

(b) Six (6) years following the completion date, the home will be free from major structural defects due to noncompliance with the building standards.

(2) Unless the parties otherwise agree in writing, the builder's warranty shall exclude the following items:

(a) Defects in outbuildings including detached garages and detached carports, except outbuildings which contain the plumbing, electrical, heating, cooling or ventilation systems serving the home; swimming pools and other recreational facilities; driveways; walkways; patios; boundary walls; retaining walls; bulkheads; fences; landscaping, including sodding, seeding, shrubs, trees, and planting; off-site improvements including streets, roads, drainage and utilities or any other improvements not a part of the home itself.

(b) Damage to real property which is not part of the home covered by the warranty and which is not included in the purchase price of the home.

(c) Any damage to the extent it is caused or made worse by any of the following:

(i) Negligence, improper maintenance or improper operation by anyone other than the builder or any employee, agent or subcontractor of the builder.

(ii) Failure by anyone other than the builder or any employee, agent or subcontractor of the builder to comply with the warranty requirements of manufacturers of appliances, equipment or fixtures.

(iii) Any change, alteration or addition made to the home by anyone after the initial occupancy by the owner, except any change, alteration or addition performed by the builder, or any employee, agent, or subcontractor of the builder.

(iv) Dampness, condensation or other damage due to the failure of the owner to maintain adequate ventilation or drainage.

(d) Any loss or damage which the owner has not taken timely action to minimize.

(e) Any defect in, or any defect caused by, materials or work supplied by anyone other than the builder, or any employee, agent or subcontractor of the builder.

(f) Normal wear and tear or normal deterioration.

(g) Loss or damage which does not constitute a defect in the construction of the home by the builder, or any employee, agent or subcontractor of the builder.

(h) Loss or damage resulting from war, accident, riot and civil commotion, water escape, falling objects, aircraft, vehicles, acts of God, lightning, windstorm, hail, flood, mud slide, earthquake, volcanic eruption, wind-driven water and changes in the level of the underground water table which are not reasonably foreseeable.

(i) Insect damage and rotting of any kind.

(j) Mold or mold damage, except in cases where the builder's negligence was a proximate or contributing cause of the mold or mold damage.

(k) Any condition which does not result in actual physical damage to the home.

(*l*) Failure of the builder to complete construction of the home.

(m) Any defect not reported in writing by registered or certified mail to the builder or insurance company, as appropriate, prior to the expiration of the period of coverage of that defect plus thirty (30) days.

(n) Consequential damages.

(o) Any loss or damage to a home caused by soil conditions or soil movement if the home is constructed on land owned by the initial purchaser and the builder obtains a written waiver from the initial purchaser for any loss or damage caused by soil conditions or soil movement.

(p) Any defect in an electrical, plumbing, heating, air conditioning or similar fixture not manufactured by the builder for which the manufacturer provides a warranty regardless of duration.

(3) The provisions of this section establish minimum required warranties and shall not be waived by the owner or reduced by the builder, provided the home is a single-family dwelling to be occupied by an owner as his home.

HISTORY: Laws, 1997, ch. 465, § 3; Laws, 2004, ch. 567, § 1; Laws, 2012, ch. 405, § 2, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment substituted "completion" for "warranty commencement" preceding "date" in (1)(b).

JUDICIAL DECISIONS

2. Limitations period.

Claim by homeowners against a builder under the New Home Warranty Act, Miss. Code Ann. § 83-58-1 et seq., for structural defects in the homeowners' home, was time-barred because (1) the claim had to be filed within six years of the home's first occupation, under Miss. Code Ann. §§ 83-58-5(1)(b), and 83-58-3(g), and (2) the home was first occupied over six years

before suit was filed. Townes v. Rusty Ellis Builder, Inc., 98 So. 3d 1046, 2012 Miss. LEXIS 483 (Miss. 2012).

Claim by homeowners against a builder under the New Home Warranty Act (NHWA), Miss. Code Ann. § 83-58-1 et seq., was not subject to Miss. Code Ann. § 15-1-5 because the NHWA limitations period applied over the more general period in Miss. Code Ann. § 15-1-41. Townes v. Rusty Ellis Builder, Inc., 98 So. 3d 1046, 2012 Miss. LEXIS 483 (Miss. 2012).

§ 83-58-17. Statutory remedy for damages arising from violations of home warranty law; common law remedies.

JUDICIAL DECISIONS

ANALYSIS

3. Builder.
4. Breach of contract.

3. Builder.

It was undisputed that plaintiffs entered into a contract with the building corporation, not debtor, its sole owner. As a result, plaintiff was not entitled to relief from debtor under the New Home Warranty Act. Hoffmeister v. Early (In re Early), 2013 Bankr. LEXIS 4128 (Bankr. S.D. Miss. Sept. 30, 2013).

4. Breach of contract.

Trial court properly granted summary judgment in favor of the sole member of a limited liability company in homeowners' action alleging negligence and breach of warranty because the "Notice to Home Buyer of the New Home Warranty Act (NHWA)" was simply a form document setting out the provisions of the NHWA, and the Notice was not a contract; the NHWA anticipates the need for homeowners to file breach-of-contract claims in addition to breach-of-home-warranty claims. Brown v. Waldron, 186 So. 3d 955, 2016 Miss. App. LEXIS 115 (Miss. Ct. App. 2016).

CHAPTER 64.

HEALTH DISCOUNT PLANS

Sec.

83-64-1. Health discount plan; disclosures to and rights of consumer; Commissioner of Insurance authorized to adopt rules and regulations to implement provisions; applicability.

§ 83-64-1. Health discount plan; disclosures to and rights of consumer; Commissioner of Insurance authorized to adopt rules and regulations to implement provisions; applicability.

(1) "Health discount plan" means a card, program, device, arrangement, contract or mechanism that purports to offer discounts or access to discounts on health care services or supplies that is not insurance or that does not provide coverage for services or benefits regulated under Section 83-9-1 et seq.

(2) A person may not sell, market, promote, advertise or otherwise distribute a health discount plan unless:

(a) Each advertisement, policy, document, information, statement or other communication regarding the health discount plan and the plan itself

contain a statement, in bold and prominent type, that the health discount plan is not insurance;

(b) The discounts offered under the health discount plan are specifically authorized by a contract with each provider of the services or supplies listed in conjunction with the plan;

(c) The health discount plan states the name, address and telephone number of the administrator of the plan;

(d) The person makes readily available to the consumer a complete, accurate and up-to-date list of providers participating in the plan that offers discounted health care services or supplies in the consumer's local area and the discounts offered by the providers;

(e) The person provides the consumer the right to cancel the health discount plan within thirty (30) days after purchase of the plan; and

(f) The person provides the consumer with a full refund of all payments made, except for a nominal processing fee, within thirty (30) days after notification of cancellation of the plan under paragraph (e) of this subsection.

(3) The Commissioner of Insurance may adopt regulations to implement this section and to establish additional requirements intended to prohibit unfair or deceptive practices relating to health discount plans.

(4) Rebates and discounts for health discount plans shall not apply to manufacturers of pharmaceuticals or supplies. This section shall not apply to the Division of Medicaid and shall not apply to pharmaceutical manufacturer discount cards.

HISTORY: Laws, 2007, ch. 553, § 7; Laws, 2010, ch. 419, § 1; Laws, 2013, ch. 316, § 1, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment deleted former (5), which contained a repealer provision that would have been effective July 1, 2013.

CHAPTER 65.

REGULATION OF VEHICLE SERVICE CONTRACTS

Sec.
83-65-103. Definitions.

§ 83-65-103. Definitions.

For the purposes of this chapter:

(a) "Commissioner" means the Commissioner of Insurance.

(b) "Service contract holder" means a person who purchases or otherwise obtains a vehicle service contract.

(c) "Vehicle service contract" means a contract or agreement that undertakes to perform or provide repair or replacement service, or provide payment for that service, for the operational or structural failure of a motor vehicle due to a defect in materials, workmanship or normal wear and tear, with or without additional provision for incidental payment or indemnity

under limited circumstances, including, but not limited to, towing, rental and emergency road service. "Vehicle service contract" also means a contract or agreement that undertakes to perform or provide one or more of the following services:

(i) The repair or replacement of tires and/or wheels on a motor vehicle damaged as a result of coming into contact with road hazards;

(ii) The removal of dents, dings or creases on a motor vehicle that can be repaired using the process of paintless dent removal without affecting the existing paint finish and without replacing vehicle body panels, sanding, bonding or painting;

(iii) The repair of chips or cracks in or the replacement of motor vehicle windshields as a result of damage caused by road hazards;

(iv) The replacement of a motor vehicle key or key-fob in the event that the key or key-fob becomes inoperable or is lost or stolen;

(v) Other services which may be approved by the Commissioner, if not inconsistent with other provisions of this chapter.

(d) "Provider" means a person who issues, makes or provides a vehicle service contract.

(e) "Reimbursement insurance policy" means a policy of insurance providing reimbursement coverage for all services which the provider is legally obligated to provide under the terms of vehicle service contracts issued or sold by the provider.

(f) "Services" means the repair, replacement or maintenance of property or indemnification for repair, replacement or maintenance for the operational or structural failure of a motor vehicle due to a defect in materials, workmanship or normal wear and tear.

(g) "Road hazard" means a hazard that is encountered while driving a motor vehicle and which may include, but not be limited to, potholes, rocks, wood debris, metal parts, glass, plastic, curbs or composite scraps.

HISTORY: Laws, 1995, ch. 302, § 2, eff from and after passage (approved February 28, 1995); Laws, 2019, ch. 358, § 1, eff from and after July 1, 2019.

Amendment Notes — The 2019 amendment, in (a), added "with or without additional provision...provide one or more of the following services" at the end of the introductory paragraph, and added (i) through (v); and added (g).

CHAPTER 73.

PORTABLE ELECTRONICS INSURANCE

Sec.

83-73-1. Definitions.
83-73-3. Licensure of vendors.
83-73-5. Requirements for sale of portable electronics insurance.
83-73-7. Authority of vendors of portable electronics.
83-73-9. Suspension or revocation of license; funding of agency expenses; deposit of monies into State General Fund.
83-73-11. Termination of portable electronics insurance.

Sec.
83-73-13. Application for license and fees.
83-73-15. Rules and regulations.

§ 83-73-1. Definitions.

For purposes of this chapter, the following terms have the following meanings:

(a) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(b) "Commissioner" means the Commissioner of Insurance for the State of Mississippi.

(c) "Customer" means a person who purchases portable electronics or services.

(d) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(e) "Location" means any physical location in the State of Mississippi or any website, call center site or similar location directed to residents of the State of Mississippi.

(f) "Portable electronics" means electronic devices that are portable in nature, their accessories and services related to the use of the device.

(g)(i) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following causes of loss: loss, theft, inoperability due to mechanical failure, malfunction, damage or other similar causes of loss. The insurance shall not exceed Seven Thousand Five Hundred Dollars ($7,500.00).

(ii) "Portable electronics insurance" does not include:

1. A service contract governed by Section 75-24-91;

2. A policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or

3. A homeowner's, renter's, private passenger automobile, commercial multiperil or similar policy.

(h) "Portable electronics transaction" means:

(i) The sale or lease of portable electronics by a vendor to a customer; or

(ii) The sale of a service related to the use of portable electronics by a vendor to a customer.

(i) "Portable electronics insurance producer" means a business entity required to be licensed under the laws of this state to sell, solicit or negotiate portable electronics insurance.

(j) "Subsidiary corporation" means any corporation in which a majority of the voting stock is owned, directly or indirectly, by another corporation.

(k) "Supervising entity" means a business entity that is a licensed insurer or insurance producer that is authorized by an insurer to supervise the administration of a portable electronics insurance program.

(*l*) "Vendor" means a business entity in the business of selling, soliciting or negotiating portable electronics transactions directly or indirectly.

HISTORY: Laws, 2012, ch. 449, § 1, eff from and after Jan. 1, 2013.

Cross References — State agencies and public officials providing information about the agency or office to the public on a website are required to regularly review and update that information, see § 25-1-117.

§ 83-73-3. Licensure of vendors.

(1) A vendor is required to hold a portable electronics insurance producer license to sell, solicit or negotiate coverage under a policy of portable electronics insurance.

(2) A portable electronics insurance producer license issued under this chapter shall authorize any employee, subsidiary corporation or authorized representative of the vendor to sell, solicit or negotiate coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(3) Notwithstanding any other provision of law, a license issued pursuant to this section shall authorize the licensee and its employees or authorized representatives to engage in those activities that are permitted in this section.

HISTORY: Laws, 2012, ch. 449, § 2, eff from and after Jan. 1, 2013.

§ 83-73-5. Requirements for sale of portable electronics insurance.

(1) At every location where portable electronics insurance is sold, solicited or negotiated to customers, brochures or other written materials shall be made available to a prospective customer which:

(a) Disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy or other source of coverage;

(b) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(c) Summarize the material terms of the insurance coverage, including:

(i) The identity of the insurer;

(ii) The identity of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the coverage; and

(v) Key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or nonoriginal manufacturer parts or equipment;

(d) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(e) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund of any applicable unearned premium.

(2) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers.

(3) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

HISTORY: Laws, 2012, ch. 449, § 3, eff from and after Jan. 1, 2013.

§ 83-73-7. Authority of vendors of portable electronics.

(1) The employees, subsidiary corporations and authorized representatives of vendors may sell, solicit or negotiate portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this chapter provided that:

(a) The employee, subsidiary corporation or authorized representative is only engaged in the sale, solicitation or negotiation of portable electronics insurance;

(b) The vendor obtains a portable electronics insurance producer license to authorize its employees, subsidiary corporations or authorized representatives to sell, solicit or negotiate portable electronics insurance pursuant to this chapter;

(c) The insurer issuing the portable electronics insurance either directly supervises or shall authorize a supervising entity to supervise the administration of the program including development of a training program for employees, subsidiary corporations and authorized representatives of the vendors. The training required by this paragraph (c) shall comply with the following:

(i) The training shall be delivered to employees, subsidiary corporations and authorized representatives of vendors who are directly engaged in the activity of selling, soliciting or negotiating portable electronics insurance;

(ii) The training may be provided in electronic form. However, if conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance product that is conducted and overseen by licensed employees of the supervising entity; and

(iii) Each employee, subsidiary corporation and authorized representative shall receive basic instruction about the portable electronics insurance offered to customers and the disclosures required under Section 83-73-5;

(d) No employee, subsidiary corporation or authorized representative of a vendor of portable electronics shall advertise, represent or otherwise hold himself out as a licensed portable electronics insurance producer.

(2) Notwithstanding any other provision of law, employees, subsidiary corporation or authorized representatives of a vendor of portable electronics shall not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage, but may receive compensation for activities under the portable electronics insurance producer license which is incidental to their overall compensation.

(3) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain the funds in a segregated or trust account, provided that the vendor is authorized by the insurer to hold the funds in an alternative manner and remits such amounts to the supervising entity within sixty (60) days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

HISTORY: Laws, 2012, ch. 449, § 4, eff from and after Jan. 1, 2013.

§ 83-73-9. Suspension or revocation of license; funding of agency expenses; deposit of monies into State General Fund.

(1) If a vendor of portable electronics or its employee, subsidiary corporation or authorized representative violates any provision of this section, the commissioner may do any of the following:

(a) After notice and hearing, impose fines not to exceed One Thousand Dollars ($1,000.00) per violation or Thirty Thousand Dollars ($30,000.00) in the aggregate for such violations and such penalty shall be deposited into the special fund of the State Treasury designated as the "Insurance Department Fund."

(b) After notice and hearing, impose other penalties that the commissioner deems necessary and reasonable to carry out the purpose of this chapter, including, but not limited to:

(i) Suspending the privilege of transacting portable electronics insurance pursuant to this section at specific business locations where violations have occurred;

(ii) Suspending or revoking the ability of individual employees, subsidiary corporations or authorized representatives to act under the license; and

(iii) Placing on probation, suspending or revoking the license of the portable electronics insurance producer.

(2) From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

(3) From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Laws, 2012, ch. 449, § 5; Laws, 2016, ch. 459, § 35, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides: "SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Amendment Notes — The 2016 amendment added (2) and (3).

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

§ 83-73-11. Termination of portable electronics insurance.

(1) Notwithstanding any other provision of law, the terms for the termination or modification of a policy of portable electronics insurance shall be as follows:

(a) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least thirty (30) days' notice.

(b) If the insurer changes the terms and conditions, then the insurer shall provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of material changes.

(c) Notwithstanding paragraph (a) of this subsection, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen (15) days' notice for nonpayment of premium, discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder.

(d) Notwithstanding paragraph (a) of this subsection, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(i) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(ii) If an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within thirty

(30) calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(e) Where a portable electronics insurance policy is terminated by a policyholder, the policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least thirty (30) days prior to the termination.

(2) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to the policy or is otherwise required by law, it shall be in writing and sent within the notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means as set forth in this subsection. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last-known mailing addresses on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's electronic mail address specified for such purpose and to its affected enrolled customers' last-known electronic mail address as provided by each enrolled customer to the insurer or vendor of portable electronics, as the case may be. For purposes of this subsection, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics, as the case may be, shall be deemed consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice or correspondence was sent.

(3) Notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor, as the case may be, by the supervising entity authorized by the insurer.

HISTORY: Laws, 2012, ch. 449, § 6, eff from and after Jan. 1, 2013.

§ 83-73-13. Application for license and fees.

(1) A sworn application for a license under this chapter shall be filed with the Mississippi Insurance Department on forms prescribed and furnished by the department.

(2) Portable electronics insurance producer licenses issued pursuant to this chapter shall continue from the date of issuance until December 31 in the second year following issuance or renewal of the license, with a minimum term of thirteen (13) months.

(3) Each vendor of portable electronics licensed under this chapter shall pay to the Mississippi Insurance Department a fee of Five Thousand Dollars ($5,000.00).

HISTORY: Laws, 2012, ch. 449, § 7, eff from and after Jan. 1, 2013.

§ 83-73-15. Rules and regulations.

The commissioner may promulgate reasonable rules and regulations to implement this chapter.

HISTORY: Laws, 2012, ch. 449, § 8, eff from and after Jan. 1, 2013.

CHAPTER 75.

HOMEOWNERS INSURANCE DISCOUNT FOR HURRICANE OR WINDSTORM DAMAGE MITIGATION

Sec.

83-75-1. Discount, rate reduction or adjustment for new home hurricane mitigation construction in certain localities.
83-75-3. Discount, rate reduction or adjustment for existing home hurricane mitigation retrofit in certain localities.
83-75-5. Definitions.
83-75-7. Rules and regulations.

§ 83-75-1. Discount, rate reduction or adjustment for new home hurricane mitigation construction in certain localities.

(1) Not later than July 1, 2013, insurance companies shall provide a premium discount or insurance rate reduction in an amount and manner as established in subsection (6) of this section and according to Section 83-75-5. In addition, insurance companies may also offer additional adjustments in deductible, other credit rate differentials, or a combination thereof, collectively referred to as adjustments. These adjustments shall be available under the terms specified in this section to any owner who builds or locates a new insurable property in Harrison, Hancock, Jackson, Stone and Pearl River Counties, to resist loss due to hurricane or other catastrophic windstorm events.

(2) Not later than July 1, 2019, insurance companies shall provide a premium discount or insurance rate reduction for new residential insurable property in an amount and manner as established in subsection (6) of this section and according to Section 83-75-5. In addition, insurance companies may also offer additional adjustments in deductible, other credit rate differentials, or a combination thereof, collectively referred to as adjustments. These adjustments shall be available under the terms specified in this section to any owner who builds or locates a new residential insurable property to resist loss

due to tornado or other catastrophic windstorm events in any county located in the State of Mississippi.

(3) Not later than July 1, 2021, insurance companies shall provide a premium discount or insurance rate reduction for new commercial insurable property in an amount and manner as established in subsection (6) of this section and according to Section 83-75-5. In addition, insurance companies may also offer additional adjustments in deductible, other credit rate differentials, or a combination thereof, collectively referred to as adjustments. These adjustments shall be available under the terms specified in this section to any owner who builds or locates a new commercial insurable property to resist loss due to hurricane, tornado or other catastrophic windstorm events in any county located in the State of Mississippi.

(4) To obtain the adjustment provided in this section, an insurable property located in this state shall be certified as constructed in accordance with (a) the 2006 or newer version of the International Residential Code, as amended, including the entire coastal construction supplement as recommended by the Mississippi Windstorm Mitigation Coordination Council; or (b) the 2012 or newer version of the International Building Code, as amended; or (c) the Fortified for Safer Living or similar programs adopted by the Insurance Institute for Business and Home Safety; or (d) any other mitigation program recommended by the Mississippi Windstorm Mitigation Coordination Council and approved by the Commissioner of Insurance. An insurable property shall be certified as conforming to the applicable building codes only after an evaluation of the insurable property has been satisfactorily completed by a building official or a certified and licensed building evaluator. An insurable property shall be certified as conforming to Fortified for Safer Living criteria only after evaluation and certification by an Insurance Institute for Business and Home Safety certified evaluator.

(5) An owner of insurable property claiming an adjustment under this section shall maintain sufficient certification records and construction records including, but not limited to, a Certificate of Occupancy denoting compliance with the applicable building code in subsection (4)(a) of this section or valid certification from the Insurance Institute for Business and Home Safety for compliance with the program described in subsection (4)(b) of this section.

(6) Insurers required to submit rates and rating plans to the commissioner shall submit an actuarially justified rating plan for any person who builds an insurable property to comply with the sets of requirements of subsection (4) of this section. An insurer is not required to provide the same amount of adjustment for a building code insurable property as the insurer would to a Fortified for Safer Living insurable property. An adjustment shall only apply to policies that provide wind coverage and may apply to that portion of the premium for wind coverage or to the total premium if the insurer does not separate out its premium for wind coverage in its rate filing. The adjustment shall apply exclusively to the premium designated for the improved insurable property. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

HISTORY: Laws, 2012, ch. 443, § 1, eff from and after July 1, 2012; Laws, 2018, ch. 311, § 1, eff from and after July 1, 2018; Laws, 2020, ch. 342, § 1, eff from and after July 1, 2020.

Editor's Notes — The 2018 amendment added (2) and redesignated the remaining subsections accordingly; and substituted "subsection (5)" for "subsection (4)" in the first sentence of (1), "subsection (3)(a)" for "subsection (2)(a)" and "subsection (3)(b)" for "subsection (2)(b)" in (4), and "subsection (3)" for "subsection (2)" in the first sentence of (5).

Amendment Notes — The 2020 amendment, in (1), substituted "subsection (6)" for "subsection (5)"; in (2), in the first sentence, inserted "for new residential insurable property" and substituted "subsection (6)" for "subsection (5)," and in the last sentence, inserted "residential"; added (3), and redesignated former (3) through (5) as (4) through (6); in (4), substituted "constructed in accordance with (a)" for "constructed (a) in accordance with," added (b), redesignated former (b) and (c) as (c) and (d), and inserted "Insurance" in (c) and in the last sentence; in (5), substituted "subsection (4)(a)" for "subsection (3)(a)" and "subsection (4)(b)" for "subsection (3)(b)," and inserted "Insurance"; and in (6), substituted "subsection (4)" for "subsection (3)."

§ 83-75-3. Discount, rate reduction or adjustment for existing home hurricane mitigation retrofit in certain localities.

(1) Not later than July 1, 2013, insurance companies shall provide a premium discount or insurance rate reduction in an amount and manner as established in subsection (5) of this section and according to Section 83-75-5. In addition, insurance companies may also offer additional adjustments in deductible, other credit rate differentials, or a combination thereof, collectively referred to as adjustments. These adjustments shall be available under the terms specified in this section to any owner who retrofits his or her insurable property in Harrison, Hancock, Jackson, Stone and Pearl River Counties to resist loss due to hurricane or other catastrophic windstorm events.

(2) Not later than July 1, 2021, insurance companies shall provide a premium discount or insurance rate reduction in an amount and manner as established in subsection (5) of this section and according to Section 83-75-5. In addition, insurance companies may also offer additional adjustments in deductible, other credit rate differentials, or a combination thereof, collectively referred to as adjustments. These adjustments shall be available under the terms specified in this section to any owner who retrofits existing commercial insurable property to resist loss due to tornado or other catastrophic windstorm events in any county located in the State of Mississippi.

(3) To obtain the adjustment provided in this section, an insurable property shall be retrofitted to one (1) of the tiered mitigation levels as defined by the Insurance Institute for Business and Home Safety, or other mitigation program, or other construction technique, or standardized code that is recommended by the Mississippi Windstorm Mitigation Coordination Council and approved by the Commissioner of Insurance. Zone three HUD code manufactured homes installed to specifications and regulations promulgated by the Commissioner of Insurance shall be considered. An insurable property shall be

certified as conforming to Fortified for Safer Homes requirements only after evaluation and certification by an Insurance Institute for Business and Home Safety certified evaluator. Certification of conformity of an insurable property with the other mitigation program, other construction technique, or other standardized code shall be made only by a building official or other certified or licensed building evaluator.

(4) An owner of insurable property claiming an adjustment under this section shall maintain sufficient certification records and construction records including, but not limited to, a certification of compliance with an approved mitigation program as promulgated by the Mississippi Windstorm Mitigation Coordination Council and approved by the Commissioner of Insurance or valid certification from the Insurance Institute for Business and Home Safety for compliance with a program described in subsection (3) of this section.

(5) Insurers required to submit rates and rating plans to the commissioner shall submit actuarially justified rating plans for any person who retrofits an insurable property to comply with the sets of alternatives provided in subsection (3) of this section. The adjustment shall only apply to policies that provide wind coverage and may apply to that portion of the premium for wind coverage or to the total premium if the insurer does not separate out its premium for wind coverage in its rate filing. The adjustment shall apply exclusively to the premium designated for the improved insurable property. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

HISTORY: Laws, 2012, ch. 443, § 2, eff from and after July 1, 2012; Laws, 2020, ch. 342, § 2, eff from and after July 1, 2020.

Amendment Notes — The 2020 amendment, in (1), substituted "subsection (5)" for "subsection (4)"; added (2), and redesignated former (2) through (4) as (3) through (5); in (3), inserted "(1)," deleted "in the Fortified for Safer Homes requirements as may from time to time be adopted" following "mitigation levels as defined," and inserted "Insurance" in the first and next-to-last sentences; in (4), inserted "Insurance" and substituted "subsection (3)" for "subsection (2)"; and in (5), substituted "subsection (3)" for "subsection (2)."

§ 83-75-5. Definitions.

[Until July 1, 2021, this section shall read:]

For the purposes of this chapter, the term "insurable property" includes single-family residential property. "Insurable property" also includes modular homes satisfying the codes, standards, or techniques as provided in Section 83-75-1 or 83-75-3. Manufactured homes or mobile homes are excluded from "insurable property," except as expressly provided in Section 83-75-3(3).

[From and after July 1, 2021, this section shall read:]

For the purposes of this chapter, the term "insurable property" includes single-family residential and commercial property. "Insurable property" also includes modular homes satisfying the codes, standards, or techniques as

provided in Section 83-75-1 or 83-75-3. Manufactured homes or mobile homes are excluded from "insurable property," except as expressly provided in Section 83-75-3(3).

Laws, 2012, ch. 443, § 3, eff from and after July 1, 2012; Laws, 2020, ch. 342, § 3, eff from and after July 1, 2020.

Amendment Notes — The 2020 amendment provided for two versions of this section; in both versions, substituted "Section 83-75-3(3)" for "Section 83-75-3(2)"in the last sentence; and in the version effective from and after July 1, 2021, inserted "and commercial" in the first sentence.

§ 83-75-7. Rules and regulations.

The Commissioner of Insurance shall promulgate such rules and regulations as are necessary to implement and administer this chapter.

HISTORY: Laws, 2012, ch. 443, § 4, eff from and after July 1, 2012.

CHAPTER 77.

HEALTH CARE SHARING MINISTRIES

Sec.

83-77-1. Health care sharing ministry defined; health care sharing ministry not to be considered to be engaged in business of insurance.

§ 83-77-1. Health care sharing ministry defined; health care sharing ministry not to be considered to be engaged in business of insurance.

(1) This chapter shall be known as the "Health Care Sharing Ministries Freedom to Share Act."

(2) A health care sharing ministry shall not be considered to be engaging in the business of insurance for purposes of this Title 83, Mississippi Code of 1972.

(3) "Health care sharing ministry" means a faith-based, nonprofit organization that is tax exempt under the Internal Revenue Code which:

(a) Limits its participants to those who are of a similar faith;

(b) Acts as a facilitator among participants who have financial or medical needs and matches those participants with other participants with the present ability to assist those with financial or medical needs in accordance with criteria established by the health care sharing ministry;

(c) Provides for the financial or medical needs of a participant through contributions from one (1) participant to another;

(d) Provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing ministry to the participants;

(e) Provides a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing ministry, as well as the amount actually published or assigned to participants for their contribution; and

(f) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance: "Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment of medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills."

HISTORY: Laws, 2014, ch. 377, § 1, eff from and after July 1, 2014.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected two typographical errors in the Notice in (3)(f) by substituting "neither its guidelines nor plan of operation" for "neither its guideline nor plan or operation." The Joint Committee ratified the correction at its July 24, 2014, meeting.

CHAPTER 79.

PROPERTY INSURANCE CLARITY ACT

Sec.

83-79-1. Short title [Repealed effective July 1, 2022].

83-79-3. Insurers authorized to transact homeowners insurance business in Mississippi required to provide certain policy and premium information to Department of Insurance; specific information to be provided [Repealed effective July 1, 2022].

83-79-5. Insurers authorized to transact homeowners insurance business in Mississippi required to provide certain policy and premium information to Department of Insurance for calendar years 2005 through 2014 [Repealed effective July 1, 2022].

83-79-7. Waiver, modification or extension for an additional time period of the reporting requirements; penalty for noncompliance with reporting requirements [Repealed effective July 1, 2022].

83-79-9. Aggregated information to be made available to the public [Repealed effective July 1, 2022].

83-79-11. Commissioner to promulgate rules to notify insurers of obligations under this chapter and clarify data requested and manner of production of data [Repealed effective July 1, 2022].

83-79-13. Repeal of chapter.

§ 83-79-1. Short title [Repealed effective July 1, 2022].

(1) This chapter shall be known and may be cited as the Property Insurance Clarity Act.

(2) It is the intent and purpose of the Legislature that this chapter shall serve to allow the Mississippi Insurance Department to receive and aggregate insurers' homeowner claims loss data for the purposes of determining the accuracy and adequacy of catastrophic models and determine the adequacy of rates by data calls as prescribed in this chapter. This chapter is not intended to and shall not create any separate cause of action.

HISTORY: Laws, 2015, ch. 322, § 1, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-3. Insurers authorized to transact homeowners insurance business in Mississippi required to provide certain policy and premium information to Department of Insurance; specific information to be provided [Repealed effective July 1, 2022].

(1)(a) Each insurance company and the Mississippi Windstorm Underwriting Association (herein after "insurers") authorized to transact homeowners insurance business in the State of Mississippi shall once every three (3) years submit to the Mississippi Insurance Department, commencing on or before October 1, 2015, for homeowners insurance policies, computations of the total amount of direct incurred losses, direct earned premiums, policy limits, reinsurance, allocated loss adjustment expense and the number of policies in force by earned house years for the prior calendar year.

(b) The insurers shall report the computations to the department by zip code.

(c) Such information shall be provided for each of the following policy categories:

(i) All homeowners policies that include windstorm coverage;

(ii) All homeowners policies that exclude windstorm coverage; and

(iii) All policies that only include windstorm coverage.

(d) The information received by the department shall be aggregated across all insurers collectively and the aggregated totals shall be arranged by zip code.

(e) Homeowners insurance policies shall include condominium insurance, dwelling fire policies, renters/tenants insurance and mobile home/manufactured housing property insurance.

(f) Creditor-placed property insurance, condominium association insurance and commercial insurance are excluded from this chapter.

(2) Based upon the information submitted to or otherwise gathered by the department, the department may post on the department website the aggregated total of the computations provided under subsection (1) of this section by zip code for the prior calendar year. The department may also post on the department website a general description of the rate-making methodology that the department allows insurers to use in establishing their homeowners rates.

(3) Each insurer authorized to transact homeowners insurance business in the state shall submit to the department catastrophe wind/hail information

pursuant to a data call by the department based on a specific catastrophic event.

HISTORY: Laws, 2015, ch. 322, § 2, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-5. Insurers authorized to transact homeowners insurance business in Mississippi required to provide certain policy and premium information to Department of Insurance for calendar years 2005 through 2014 [Repealed effective July 1, 2022].

No later than October 1, 2015, each insurer authorized to transact homeowners insurance business in this state shall provide the information required pursuant to Section 83-79-3(1), for the calendar years 2005 through 2014. Voluntary submissions of the information required by Section 83-79-3(1) for calendar years prior to 2005, may be submitted and shall be compiled by the department and may be posted by the department on the department website in the same manner. Based upon the submitted information, the department shall compile aggregate totals, commencing with calendar year 2005, and may post those aggregate totals on the department website pursuant to Section 83-79-3(2).

HISTORY: Laws, 2015, ch. 322, § 3, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-7. Waiver, modification or extension for an additional time period of the reporting requirements; penalty for noncompliance with reporting requirements [Repealed effective July 1, 2022].

(1) Upon written request of an insurer, the commissioner may waive, modify, or extend for an additional time period, for good cause shown, the reporting requirements imposed by this chapter. The request shall demonstrate good cause for waiving, modifying, or extending the reporting requirements. Good cause may include, but is not limited to, the insurer's limited percentage of the total homeowners insurance market in this state, or the undue burden of compiling and reporting the computations, data, and other information required by this chapter due to the manner, format, or method in which the insurer has stored the computations, data, or other information required.

(2) Any insurer that fails to timely comply with the reporting requirements imposed by this chapter shall be given notice by the department of such failure and provided ninety (90) days within which to comply. Any insurer that fails to comply on or before the ninetieth day shall be fined Two Thousand Five Hundred Dollars ($2,500.00) per month by the department until the date of

compliance. Any funds collected pursuant to this subsection shall be deposited into the Municipal Fire Protection Fund.

HISTORY: Laws, 2015, ch. 322, § 4, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-9. Aggregated information to be made available to the public [Repealed effective July 1, 2022].

(1) Any information submitted to the department by an insurer pursuant to this chapter shall be reported to the department pursuant to the market analysis provisions in Section 83-5-205(4). Further, pursuant to Section 83-5-209(7), all data reported to the commissioner or his designee as part of this market analysis shall also be considered as confidential and privileged materials and afforded all protections from disclosure allowed under Section 83-5-209(7).

(2) Once the information from all of the insurers is aggregated, such aggregated information is not a commercially valuable trade secret or otherwise confidential and the department shall provide such information in a digital format in accordance with this chapter upon the request of any person as provided in Section 25-61-1 et seq., but shall not release any company specific data.

HISTORY: Laws, 2015, ch. 322, § 5, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-11. Commissioner to promulgate rules to notify insurers of obligations under this chapter and clarify data requested and manner of production of data [Repealed effective July 1, 2022].

(1) The commissioner shall promulgate rules consistent with this chapter to notify insurers of their obligations under this chapter and to clarify the data requested and the manner of production of such data.

(2) The commissioner may add any and all reasonable data to the data calls created by this chapter, and all such data shall be controlled by this chapter.

(3) The commissioner may prepare a report on the aggregate data collected that may give his findings and conclusions, which shall be a public record. Any such report shall not disclose the individual data of any insurer.

(4) The commissioner may assess costs to insurers for the cost incurred by the commissioner for outside experts and consultants in preparing the data calls and analysis of the aggregate data, and such costs shall be assessed to the insurers on a pro rata basis based on average premium volume for the last five (5) years for the insurance being surveyed.

(5) Nothing in this chapter shall limit the powers and duties of the department and commissioner as provided in other laws.

HISTORY: Laws, 2015, ch. 322, § 6, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-13. Repeal of chapter.

This chapter shall stand repealed from and after July 1, 2022.

HISTORY: Laws, 2015, ch. 322, § 7, eff from and after July 1, 2015.

CHAPTER 81.

MISSISSIPPI DIRECT PRIMARY CARE ACT

Sec.

83-81-1. Short title.
83-81-3. Definitions.
83-81-5. Direct primary care agreement not an insurance product.
83-81-7. Primary care provider not required to obtain license under this chapter to market or sell direct primary care agreement.
83-81-9. Direct primary care agreement requirements; disclaimer.
83-81-11. Acceptance or discontinuation of patients.

§ 83-81-1. Short title.

This chapter shall be known as the "Mississippi Direct Primary Care Act."

HISTORY: Laws, 2015, ch. 369, § 1, eff from and after July 1, 2015.

§ 83-81-3. Definitions.

As used in this chapter, the following words and phrases have the meanings as defined in this section unless the context clearly indicates otherwise:

(a) "Primary care provider" means an individual or other legal entity that is licensed, registered or otherwise authorized to provide primary care services in this state under Chapter 25, Title 73, Mississippi Code of 1972. Primary care provider includes an individual or other legal entity alone or with others professionally associated with the individual or other legal entity.

(b) "Direct primary care agreement" means a contract between a primary care provider and an individual patient or his or her legal representative or between a primary care provider and an employer on behalf of its employees in which the primary care provider agrees to provide primary care services to the individual patient for an agreed-upon fee and period of time.

(c) "Direct primary care service" means a service that is provided by charging a periodic fee-for-services; not billing any third parties on a fee-for-service basis for the individual covered by the direct primary care

agreement; and allowing for a per visit fee to be charged to the patient at the time of service.

(d) "Primary care service" includes, but is not limited to, the screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of disease or injury within the competency, training, and scope of the primary care provider. This may also include fees for advanced technology or techniques used within the practice that may offer benefits for improved patient engagement.

HISTORY: Laws, 2015, ch. 369, § 2, eff from and after July 1, 2015.

§ 83-81-5. Direct primary care agreement not an insurance product.

A direct primary care agreement shall not be considered to be an insurance product nor shall the primary care provider be considered to be engaging in the business of insurance for the purpose of this Title 83, Mississippi Code of 1972.

HISTORY: Laws, 2015, ch. 369, § 3, eff from and after July 1, 2015.

§ 83-81-7. Primary care provider not required to obtain license under this chapter to market or sell direct primary care agreement.

A primary care provider or agent of a primary care provider is not required to obtain a certificate of authority or license under this chapter to market, sell, or offer to sell a direct primary care agreement.

HISTORY: Laws, 2015, ch. 369, § 4, eff from and after July 1, 2015.

§ 83-81-9. Direct primary care agreement requirements; disclaimer.

To offer a direct primary care service, the primary care provider must obtain a completed direct primary care agreement for each patient obtaining direct primary care services. In order to be considered a direct primary care agreement for the purposes of this section, the direct primary care agreement must meet all of the following requirements:

(a) Be in writing;

(b) Be signed by the individual patient or his or her legal representative and be made available for the records of the primary care provider or agent of the primary care provider;

(c) Allow either party to terminate the agreement on written notice to the other party;

(d) Describe the scope of primary care services that are covered by the periodic fee;

(e) Specify the periodic fee for ongoing care under the agreement;

(f) Specify the duration of the agreement, any automatic renewal periods, and prohibit the prepayment of the agreement. Upon discontinuing

the agreement, all unearned funds, as determined by the lesser of normal undiscounted fee-for-service charges that would have been billed in place of the agreement or the remainder of the membership contract, are returned to the patient. Upon termination of the agreement, the patient shall not be liable for the remainder of payment associated with the agreement or membership contract. However, the patient shall be responsible for the true cost of services rendered regardless of when the contract is terminated.

(g) Prominently state in writing the following:

(i) That the agreement is not health insurance;

(ii) That the agreement standing alone does not satisfy the health benefit requirements as established in the federal Affordable Care Act; and

(iii) That, without adequate insurance coverage in addition to this agreement, the patient may be subject to fines and penalties associated with the federal Affordable Care Act.

HISTORY: Laws, 2015, ch. 369, § 5, eff from and after July 1, 2015.

Federal Aspects— Patient Protection and Affordable Care Act, see Pub. L. No. 111-148, 124 Stat. 119.

§ 83-81-11. Acceptance or discontinuation of patients.

Those primary care providers who offer direct primary care services to their patients may not decline to accept new direct primary care patients or discontinue care to existing patients solely because of the patient's health status. A direct primary care provider may decline to accept a patient if the practice has reached its maximum capacity, or if the patient's medical condition is such that the provider is unable to provide the appropriate level and type of primary care services the patient requires. So long as the direct primary care provider provides the patient notice and opportunity to obtain care from another physician, the direct primary care provider may discontinue care for direct primary care patients if:

(a) The patient fails to pay the periodic fee;

(b) The patient has performed an act of fraud;

(c) The patient repeatedly fails to adhere to the recommended treatment plan;

(d) The patient is abusive and presents an emotional or physical danger to the staff or other patients of the direct practice;

(e) The direct primary care provider discontinues operation as a direct primary care provider; or

(f) The direct primary care physician feels that the relationship is no longer therapeutic for the patient due to a dysfunctional physician/patient relationship.

HISTORY: Laws, 2015, ch. 369, § 6, eff from and after July 1, 2015.

CHAPTER 83.

LIMITED LINES TRAVEL INSURANCE ACT

Sec.
83-83-1. Short title.
83-83-3. Definitions.
83-83-5. Requirements.
83-83-7. Registration.
83-83-9. Policy.
83-83-11. Responsibility.
83-83-13. Enforcement.

§ 83-83-1. Short title.

This chapter shall be known as the "Limited Lines Travel Insurance Act."

HISTORY: Laws, 2015, ch. 347, § 1, eff from and after Jan. 1, 2016.

§ 83-83-3. Definitions.

As used in this chapter, unless the context otherwise requires:

(a) "Commissioner" means the Commissioner of Insurance for the State of Mississippi.

(b) "Limited lines travel insurance producer" means a:

(i) Licensed managing general agent or third-party administrator; or

(ii) Licensed insurance producer, including a limited lines producer designated by an insurer as the travel insurance supervising entity as set forth in Section 83-83-11.

(c) "Offer and disseminate" means providing general information, including a description of the coverage and price, as well as processing the application, collecting premiums, and performing other nonlicensable activities permitted by the state.

(d) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including, but not limited to:

(i) Interruption or cancellation of trip or event;

(ii) Loss of baggage or personal effects;

(iii) Damages to accommodations or rental vehicles; or

(iv) Sickness, accident, disability or death occurring during travel.

Travel insurance does not include major medical plans which provide comprehensive medical protection for travelers with trips lasting six (6) months or longer, including, for example, those working overseas as an ex-patriot or military personnel being deployed.

(e) "Travel retailer" means a business entity that makes, arranges or offers travel services and may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

HISTORY: Laws, 2015, ch. 347, § 2, eff from and after Jan. 1, 2016.

§ 83-83-5. Requirements.

Notwithstanding any other provision of law:

(a) The commissioner may issue to an individual or business entity that has filed with the commissioner an application for such limited license in a form and manner prescribed by the commissioner, a limited lines travel insurance producer license which authorizes the limited lines travel insurance producer to sell, solicit or negotiate travel insurance through a licensed insurer.

(b) A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity ("licensed business entity") license only if the following conditions are met:

(i) The limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

1. A description of the material terms or the actual material terms of the insurance coverage;

2. A description of the process for filing a claim;

3. A description of the review or cancellation process for the travel insurance policy; and

4. The identity and contact information of the insurer and limited lines travel insurance producer.

(ii) At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register on a form prescribed by the commissioner of each travel retailer that offers travel insurance on the limited lines travel insurance producer's behalf. The register shall be maintained and updated by the limited lines travel insurance producer and shall include the name, address and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations, and the travel retailer's federal tax identification number. The limited lines travel insurance producer shall submit such register to the Department of Insurance upon reasonable request. The limited lines travel insurance producer shall also certify that the travel retailer registered complies with 18 USC 1033.

(iii) The limited lines travel insurance producer has designated one of its employees who is a licensed individual producer as the person (a "designated responsible producer" or "DRP") responsible for the limited lines travel insurance producer's compliance with the travel insurance laws, rules and regulations of the state.

(iv) The DRP, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer.

(v) The limited lines travel insurance producer has paid all applicable insurance producer licensing fees as set forth in applicable state law.

(vi) The limited lines travel insurance producer requires each employee and authorized representative of the travel retailer whose duties

include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the commissioner. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

(vii) Limited lines travel insurance producers, and those registered under their license, are exempt from the examination requirements and the continuing education requirements of Chapter 17 of Title 83, Mississippi Code of 1972.

(c) Any travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that:

(i) Provide the identity and contact information of the insurer and the limited lines travel insurance producer;

(ii) Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(iii) Explain that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage;

(d) A travel retailer's employee or authorized representative, who is not licensed as an insurance producer, may not:

(i) Evaluate or interpret the technical terms, benefits and conditions of the offered travel insurance coverage;

(ii) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(iii) Hold himself or itself out as a licensed insurer, licensed producer, or insurance expert.

HISTORY: Laws, 2015, ch. 347, § 3, eff from and after Jan. 1, 2016.

§ 83-83-7. Registration.

Notwithstanding any other provision in law, a travel retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this chapter, is authorized to do so and receive related compensation, upon registration by the limited lines travel insurance producer as described in Section 83-83-5(b)(ii).

HISTORY: Laws, 2015, ch. 347, § 4, eff from and after Jan. 1, 2016.

§ 83-83-9. Policy.

Travel insurance may be provided under an individual policy or under a group or master policy.

HISTORY: Laws, 2015, ch. 347, § 5, eff from and after Jan. 1, 2016.

§ 83-83-11. Responsibility.

As the insurer designee, the limited lines travel insurance producer is responsible for the acts of the travel retailer and shall use reasonable means to ensure compliance by the travel retailer with this chapter.

HISTORY: Laws, 2015, ch. 347, § 6, eff from and after Jan. 1, 2016.

§ 83-83-13. Enforcement.

The limited lines travel insurance producer and any travel retailer offering and disseminating travel insurance under the limited lines travel insurance producer license shall be subject to the provisions of Sections 83-5-29 through 83-5-51 and Section 83-17-71.

HISTORY: Laws, 2015, ch. 347, § 7, eff from and after Jan. 1, 2016.

CHAPTER 85.

OWN RISK AND SOLVENCY ASSESSMENT ACT

Sec.

83-85-1. Title.
83-85-3. Own Risk and Solvency Assessment (ORSA) purpose and scope.
83-85-5. Definitions.
83-85-7. Risk management framework.
83-85-9. ORSA requirement.
83-85-11. ORSA Summary Report.
83-85-13. Exemption.
83-85-15. Contents of ORSA Summary Report.
83-85-17. Confidentiality.
83-85-19. Sanctions.
83-85-21. Severability clause.

§ 83-85-1. Title.

This chapter shall be known and may be cited as the "Own Risk and Solvency Assessment Act."

HISTORY: Laws, 2017, ch. 306, § 11, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-3. Own Risk and Solvency Assessment (ORSA) purpose and scope.

The purpose of this chapter is to provide the requirements for maintaining

a risk management framework and completing an Own Risk and Solvency Assessment (ORSA) and provide guidance and instructions for filing an ORSA Summary Report with the insurance commissioner of this state. The requirements of this chapter shall apply to all insurers domiciled in this state unless exempt pursuant to Section 83-85-13.

HISTORY: Laws, 2017, ch. 306, § 12, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-5. Definitions.

As used in this chapter, the following words shall have the meaning ascribed herein unless the context clearly requires otherwise:

(a) "Insurance group" means, for the purpose of conducting an ORSA, those insurers and affiliates included within an insurance holding company system as defined in Section 83-6-1(d).

(b) "Insurer" shall have the same meaning as set forth in Section 83-6-1(e), except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(c) "Own Risk and Solvency Assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurance group's current business plan, and the sufficiency of capital resources to support those risks.

(d) "ORSA Guidance Manual" means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners (NAIC) and as amended from time to time. A change in the ORSA Guidance Manual shall be effective on the January 1 following the calendar year in which the changes have been adopted by the NAIC.

(e) "ORSA Summary Report" means a confidential high-level summary of an insurer or insurance group's ORSA.

HISTORY: Laws, 2017, ch. 306, § 13, eff from and after Jan. 1, 2018.

§ 83-85-7. Risk management framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. This requirement may be satisfied if the insurance

group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

HISTORY: Laws, 2017, ch. 306, § 14, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-9. ORSA requirement.

Subject to Section 83-85-13, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

HISTORY: Laws, 2017, ch. 306, § 15, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-11. ORSA Summary Report.

(1) Upon the commissioner's request, and no more than once each year, an insurer shall submit to the commissioner an ORSA Summary Report or any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer and/or the insurance group of which it is a member. Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report(s) required by this subsection if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(2) The report(s) shall include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his/her belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA Summary Report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

(3) An insurer may comply with subsection (1) by providing the most recent and substantially similar report(s) provided by the insurer or another

member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

HISTORY: Laws, 2017, ch. 306, § 16, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as this section]."

§ 83-85-13. Exemption.

(1) An insurer shall be exempt from the requirements of this chapter, if:

(a) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than Five Hundred Million Dollars ($500,000,000.00); and

(b) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than One Billion Dollars ($1,000,000,000.00).

(2) If an insurer qualifies for exemption pursuant to paragraph (a) of subsection (1), but the insurance group of which the insurer is a member does not qualify for exemption pursuant to paragraph (b) of subsection (1), then the ORSA Summary Report that may be required pursuant to Section 83-85-11 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for any combination of insurers provided any combination of reports includes every insurer within the insurance group.

(3) If an insurer does not qualify for exemption pursuant to paragraph (a) of subsection (1), but the insurance group of which it is a member qualifies for exemption pursuant to paragraph (b) of subsection (1), then the only ORSA Summary Report that may be required pursuant to Section 83-85-11 shall be the report applicable to that insurer.

(4) An insurer that does not qualify for exemption pursuant to subsection (1) may apply to the commissioner for a waiver from the requirements of this chapter based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance

group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one (1) state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(5) Notwithstanding the exemptions stated in this section:

(a) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

(b) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report if the insurer has Risk-Based Capital for company action level event as defined in Sections 83-5-401 through 83-5-427, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in Part 1, Chapter 39, Title 19 of the Mississippi Administrative Code, or otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(6) If an insurer that qualifies for an exemption pursuant to subsection (1) subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one (1) year following the year the threshold is exceeded to comply with the requirements of this chapter.

HISTORY: Laws, 2017, ch. 306, § 17, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-15. Contents of ORSA Summary Report.

(1) The ORSA Summary Report shall be prepared consistent with the ORSA Guidance Manual, subject to the requirements of subsection (2) of this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

(2) The review of the ORSA Summary Report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

HISTORY: Laws, 2017, ch. 306, § 18, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage,

except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-17. Confidentiality.

(1) Documents, materials or other information, including the ORSA Summary Report, in the possession of or control of the Department of Insurance that are obtained by, created by or disclosed to the commissioner or any other person under this chapter, is recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to Sections 25-61-1 through 25-61-17, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer.

(2) Neither the commissioner nor any person who received documents, materials or other ORSA-related information, through examination or otherwise, while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this chapter shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the commissioner's regulatory duties, the commissioner:

(a) May, upon request, share documents, materials or other ORSA-related information, including the confidential and privileged documents, materials or information subject to subsection (1) of this section, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college with the NAIC and with any third-party consultants designated by the commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(b) May receive documents, materials or other ORSA-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this chapter, consistent with this subsection that shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this chapter, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(ii) Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this chapter remains with the commissioner and the NAIC's or a third-party consultant's use of the information is subject to the direction of the commissioner;

(iii) Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed;

(iv) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this chapter is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production;

(v) Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this chapter; and

(vi) In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(4) The sharing of information and documents by the commissioner pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the commissioner under this section or as a result of sharing as authorized in this chapter.

(6) Documents, materials or other information in the possession or control of the NAIC or a third-party consultants pursuant to this chapter shall be confidential by law and privileged, shall not be subject to the provisions of Section 25-61-1 through 25-61-17, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

HISTORY: Laws, 2017, ch. 306, § 19, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-19. Sanctions.

Any insurer failing, without just cause, to timely file the ORSA Summary Report as required in this chapter shall be required, after notice and hearing, to pay a penalty of One Hundred Dollars ($100.00) for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is Ten Thousand Dollars ($10,000.00). The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

HISTORY: Laws, 2017, ch. 306, § 20, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-21. Severability clause.

If any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this chapter which can be given effect without the invalid provision or application, and to that end the provisions of this chapter are severable.

HISTORY: Laws, 2017, ch. 306, § 21, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-19. Sanctions.

Any insurer failing, without just cause, to timely file the ORSA Summary Report as required in this chapter shall be required, after notice and hearing, to pay a penalty of One Hundred Dollars ($100.00) for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is Ten Thousand Dollars ($10,000.00). The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

HISTORY: Laws, 2017, ch. 306, § 20, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-21. Severability clause.

If any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this chapter which can be given effect without the invalid provision or application, and to that end the provisions of this chapter are severable.

HISTORY: Laws, 2017, ch. 306, § 21, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."